

The Mental Health Bill 2006 – a social work perspective

Roger Hargreaves¹

This article considers the government's current attempt to amend the Mental Health Act 1983 from the perspective of social work, and in particular from the viewpoint of Approved Social Workers (ASWs). It reflects the state of play as it was immediately after the Third Reading in the House of Lords on 6 March 2007.

ASWs have no formal role in the criminal processes in Part III of the Mental Health Act, and so it is perhaps not surprising that they have found it difficult to get excited about the 'Home Office agenda' which has tended to dominate the debate on the reform of the legislation over the last eight years. They are mainly concerned with the civil detention process in Part II, under which they assess in the order of 72,000 people per year of whom around 47,000 will subsequently be detained.² By contrast, the DSPD (dangerous severe personality disorder) group which has so exercised the government is estimated to contain no more than about 2000 people³ who will very rarely be made subject to the civil procedures - in 21 years as a practising Mental Welfare Officer and ASW I was never once asked to detain someone on the grounds of 'psychopathic disorder'.

ASWs also find much of the debate about the entry criteria and the exclusions to be rather academic, given that the existing criteria would allow detention in a much wider range of circumstances than would be considered reasonable at present. As Baroness Murphy pointed out in the debate in the Lords on 8 January 2007,⁴ "the law has been used as an excuse" – psychiatrists' (and ASWs') frequent claims that the Act prevents them from admitting particular individuals are largely bogus, but are made in order to justify their preserving scarce treatment facilities for those who are the most ill or who can derive the most benefit. Widening the criteria in the absence of a major expansion of facilities and a change in the professional consensus as to when detention is appropriate will therefore make very little difference to actual practice, given that in the present Bill, as opposed to the abandoned 2004 draft Bill, the professionals retain the discretion *not* to detain even where the minimum conditions for doing so are met.

1 'Lead' on the Mental Health Bill for the British Association of Social Workers; formerly an Approved Social Worker.

2 In-patients formally detained in hospital under the Mental Health Act 1983, England 2005, The Information Centre 2006; Admission of patients to mental health facilities in Wales, 2003-4, Report no SB/69/2004, National

Assembly for Wales; Detained - Social Services Inspectorate inspection of ASW services in 10 local authorities, February 2001

3 *Managing Dangerous People With Severe Personality Disorder, proposals for policy development, Department of Health July 1999*

4 *Hansard (HL) Debates 8/1/07 Column 76*

Community Treatment Orders and Responsible Clinicians

ASWs have also made only a limited input into the debates about two of the government's other 'flagship' proposals, for Community Treatment Orders (CTOs) and the replacement of the Responsible Medical Officer (RMO) by the multi-professional Responsible Clinician (RC). Whilst the social work consensus on CTOs would almost certainly be in favour of very tight criteria as per the amendment made at Report Stage in the Lords,⁵ many ASWs will remember the ballyhoo in 1995 about Supervised Discharge, now applied to only 600 people per year⁶ – even fewer than Guardianship – and will note that a succession of recent judicial decisions⁷ has given RMOs powers under Section 17 which equate very closely to the proposed CTO but which they have hardly been rushing to use.

There has been concern that, in the present risk-averse climate, professionals may be tempted to impose CTOs to 'cover their backs', and also that they will be used as a means of discharging patients who are not fully well in order to free beds; indeed, the government makes it clear in the Regulatory Impact Assessment that it expects substantial savings from reduced bed occupancy.⁸

However, as against this, there is a general understanding that it is unwise to invoke community powers unless the patient is highly likely to co-operate with them (and with any conditions attached to them), since the professionals otherwise put themselves at severe risk of censure when the patient does something for which the public and the media will hold them responsible but which they were powerless to prevent. Once any initial over-enthusiasm has died away, therefore, CTOs are likely to be applied mainly to the narrow band of patients who will not respond to 'assertive outreach' alone but who are not so alienated as to be unsupervisable regardless of their legal status. There has, for instance, been much talk of patients being required to abstain from alcohol or illicit drug use, but experienced ASWs know that unless the patient is under close supervision, for instance living in a 24-hour staffed hostel, it will be impossible to police such conditions and there would therefore be little point in making them unless the patient was strongly minded to comply with them in any event.

ASWs have also shown limited interest in the prospect of becoming RCs, although this may have something to do with their average age, which is higher than that of consultant psychiatrists;⁹ the immediate career concern of most is about the status of the role of Approved Mental Health Professional (AMHP) to which the government is expecting them to transfer. Even for the mere 10% who are under 35,¹⁰ it may take several years to develop career pathways to the RC role, and the creation of satisfactory governance arrangements may be problematic given that only about 10% of social workers are members of their professional association, the British Association of Social Workers (BASW,) and that their regulatory body, the General Social Care Council, has been functioning only since 2001. However, these things will be less of an obstacle if the role remains as amended by the Lords, as basically that of an overarching care manager, with no powers to impose or to extend compulsion other than with a concurring opinion from a psychiatrist, since this is essentially what ASWs do already.

5 *Ibid* 26/2/07 Column 1418

6 *A Question of Numbers: the potential impact of community-based treatment orders in England and Wales*, Simon Lawton-Smith, King's Fund September 2005

7 Jones, R *Mental Health Act Manual*, 10th Edition 1-213 *et seq*

8 *Mental Health Bill 2006, Regulatory Impact Assessment* November 2006 para 55

9 *The Department of Health stated in its evidence to the Joint Committee on the Draft Mental Health Bill (Ev 483) that at September 2003 66% of consultant psychiatrists were under 50; a survey (unpublished) of local authorities conducted in February 2006 by the Association of Directors of Social Services (ADSS) found that 61% of ASWs were under 50*

10 *ADSS survey, ibid*

The government's proposal, however, is that non-medical RCs should assume all the powers of the existing RMO, its argument being that it will not otherwise be possible to substitute them for scarce (and expensive) psychiatrists. It has not so far expanded on its reasons for believing that non-medics can make statutory decisions which require "objective medical expertise" despite being challenged to do so in the Lords, but it would appear from its reply to questions from the Joint Committee on Human Rights (JCHR) that it thinks this would depend on the individual having some sort of "medical qualifications".¹¹ However, if that is the test, it will be easier to satisfy in the case of psychology and nursing than of social work, which is not a health profession. The decisions of social workers under the present Act are made from an explicitly non-medical perspective which is intended, as the JCHR¹² pointed out, to be in "creative tension" with the medical viewpoint, and whilst many ASWs will already possess the level of "medical expertise" set out in the draft regulations (which is not especially high) they will have acquired this more from experience and observation than from systematic formal training which can be validated.

Nearest Relatives

ASWs do have an immediate interest in the government's proposals in respect of Nearest Relatives since it is they, as AMHPs, who will have to administer them. The original 1959 scheme was straightforward, with a simple hierarchical list of blood relatives, who could be counted only if they were ordinarily resident in the United Kingdom, but it was made more complex in 1983 in order to accommodate non-blood relationships of long-standing and to give priority to carers, and this introduced a degree of subjectivity into the decision as to who should be consulted by the ASW; and it has been made more complex still by caselaw, and in particular by *R(E) v Bristol City Council*,¹³ which gives ASWs a potentially very broad discretion not to consult the Nearest Relative if it would cause the patient "significant distress."

In addition, family structures are much more intricate than they were in 1959, and families more dispersed, with many people resident in more than one country. ASWs often have to work their way through family trees involving multiple separations, cohabitations, divorces and step-relationships, and parents who spend the winter in Spain, before they even consider whether one or other relative 'ordinarily cares for' the patient, and if the patient is under 18 and from a 'fractured family', the identity of their Nearest Relative may depend on family law. Richard Jones, in the 10th Edition of his *Mental Health Act Manual*¹⁴, devotes no less than 12 pages to commentary on the subject of identification and consultation, and even then does not detail the caselaw around parental responsibility.

This would be less of a problem if ASWs could determine the identity of the Nearest Relative on the basis of full information about family structure and roles and with time to consult their lawyers, but in practice they are often wrestling with this question late at night, in the house of a patient they have not met before and for whom they have no records, and whilst all hell is breaking loose around them. Not surprisingly, they sometimes get it wrong, and although they are only required by Section 11 to consult with the person "appearing to be the nearest relative" and are "not required to don the mantle of Sherlock Holmes"¹⁵ by making extensive enquiries, it is not possible for them to be certain that a court would regard them as having acted with reasonable care if they make a mistake. It would be more likely to do so if they were

11 *Joint Committee on Human Rights, Legislative Scrutiny, Mental Health Bill, January 2007 Appendix 3 page 53*

12 *Ibid para 56*

13 *R (on the application of E) v Bristol City Council [2005] EWHC 74 QBD(Admin)*

14 *Mental Health Act Manual (10th ed.) (2006) (Sweet & Maxwell).*

15 *R (on the application of WC) v South London and Maudsley NHS Trust and David Orekeye [2001] EWHC Admin 1025; [2001] MHLR 187, para 28*

making a subjective judgement, for instance about the identity of the main carer, but much less likely to do so if they made an error in law, for instance by misinterpreting the provisions of the Children Act and accompanying caselaw relating to the status of an unmarried father, even though this would be outside the area of competence of most ASWs, who are now no longer even in the same local authority department as children-and-families workers (and it will be even more outside the competence of AMHPs from a health background). In consequence, when hospitals are made aware, often by the patient's lawyer, that the wrong person was consulted in respect of an admission under Section 3, there is a tendency for them to act self-protectively and to discharge the section immediately, regardless of the safety of patient or public or indeed of the strict legal necessity of doing so.

The government's proposals would make this scheme even more complex, and therefore open up yet more possibilities of error, without achieving very much for the most vulnerable patients. It proposes that patients should be able to apply to the County Court for displacement of their Nearest Relative on the grounds that they are "not a suitable person to act as such", but it also recognises, in the Regulatory Impact Assessment, that Nearest Relatives in that situation are very likely to contest the application,¹⁶ which means that the patient will need to be capable of instructing a solicitor and providing evidence of unsuitability and if necessary of facing their relative (and their lawyer) in court. In practice, this is not a course which most patients are likely to be able to contemplate or have the ability to carry through, even with advocacy and legal support, bearing in mind that the "unsuitable" Nearest Relative may be someone who has been abusing or oppressing them for years and who they are in fear of. In addition, it is likely to be difficult for them to prove "unsuitability" unless they can adduce extensive social work and possibly medical evidence.

An AMHP will have the power to make an application on the same ground, but no *duty* to do so even if the Nearest Relative is patently unsuitable, and bearing in mind the costs involved in a contested application, local authorities are likely to refuse to fund such actions unless the Nearest Relative is obstructing the wishes of the professionals. This 'right' will not therefore be a practical reality for most patients unless there is a procedure whereby they can require the local authority to take up a reasonable case for displacement.

Alternative approaches

The alternative proposed by the Mental Health Alliance would give precedence to the patient's own choice, albeit only from the present list of eligible relatives in Section 26, if they were judged by an AMHP or other "prescribed person" as having the capacity to make such a choice. This might not always be the case at the time of admission where the patient was very disturbed or the circumstances very fraught, but the Alliance proposal would give them the option of nominating a "named person" as Nearest Relative, or of changing their nomination, at any point in the future. Failing such a nomination, the hierarchical system would apply as at present.

This scheme differs substantially from the "nominated person" proposals in the 2004 Draft Bill in that, whilst they would also have given precedence to the patient's nomination (which was not limited to a list), the AMHP would then have had the power to reject that nomination on the grounds either that the person was not eligible due to their health status, an issue which at present can only be decided by the County Court, or more broadly that they were not "suitable." Many ASWs felt uncomfortable about having this level of discretion, which would have been an invitation to bar someone who was likely to

¹⁶ Regulatory Impact Assessment Annex A para 41 page 56

disagree with them; the present system may not produce the outcome the patient wants, but the professionals *also* have to work with whoever it throws up unless they behave in such a way as to create grounds for displacement (or the ASW can avoid contacting them on the grounds of likely distress to the patient.) The Alliance scheme would limit the AMHP's discretion to the application of a simple capacity test, and mistakes and legal challenges would be much less likely since, in a great many if not the majority of cases, the AMHP would be holding the patient's written nomination.

The weakness of the Alliance proposal, however, is that, since it is simply tacked onto the existing scheme, the nominated Nearest Relative would then acquire all the existing powers, including the power to make an application, to discharge a Section 2 and to object to a Section 3. The 2004 'nominated person', by contrast, was essentially a patient's representative lacking formal powers. Not surprisingly, the government is objecting to patients having a virtually-unfettered right to nominate a Nearest Relative who would then have the power either to discharge them or to bar their admission; and it would also be incompatible with the (very rarely-used) power to make an application, since where a hierarchical Nearest Relative was proposing to do so, the first duty of the AMHP on arrival would be to inform the patient that they had the right to nominate someone else.

Basically, it is just not possible to frame a scheme which preserves the existing powers of the Nearest Relative, which carers and indeed many patients see as being very important, whilst giving patients unfettered nominating rights; but if those rights were fettered by the AMHP's discretion, it would open up an opportunity for the misuse of professional power which does not exist at present. The 1959 scheme was logical and consistent, as was the 2004 "nominated person", but they are quite different in concept and any attempt to 'mix and match' is bound to result in illogicalities and inconsistencies which AMHPs will find impossible to resolve. At Third Reading in the Lords, the Alliance introduced a compromise amendment¹⁷ which the government agreed to "take away for consideration" and which would involve the discretion being exercised not by the AMHP but by three-member panels of local authority councillors or hospital managers; however, although this would largely avoid the conflict of interest, it raises a whole host of other practical and procedural issues.

The civil detention process

The primary concerns of ASWs, however, are not surprisingly around the civil process for assessment and admission. Given the impact which this has on the rights and freedoms of so many people, it is remarkable, even allowing for the fact that it is marginal to the 'Home Office agenda', that it has attracted so little attention over the last eight years. This was certainly not the case in 1983, when concerns about the misuse of medical authority and the absence of a strong social counterbalance led to the creation of the ASW¹⁸, and this apparent lack of interest is perhaps an indication of how well that role has functioned since, both in ensuring the fair application of the law and in 'oiling the wheels' of the process.

In addition, much more so than in 1983 the recent debate has been shaped by caselaw, the volume of which is in turn influenced by the level of legal activity and the availability of Legal Aid to fund it, and (with the exception of cases about use of police powers under Section 136) this has been focussed mainly on patients who have already been detained for substantial periods. Patients usually acquire lawyers only when they apply to the Mental Health Review Tribunal (MHRT), but only about 38% of Section 2

¹⁷ *Hansard (HL) Debates 6/3/07 Column 133*

¹⁸ *Hargreaves, R A Mere Transporter - the legal role of the Approved Social Worker, Journal of Mental Health Law, Edition 4 December 2000*

patients make such an application and only 25% remain detained for long enough to get a hearing¹⁹, and by the time of a Section 3 hearing the circumstances of their admission have often faded into the background. Earlier access to advocacy services might increase the 'visibility' of these circumstances to lawyers, but the situation would still not be remotely comparable to the criminal detention process where lawyers are involved almost from the beginning.

A further factor may be that the major concerns in recent times have tended to be not about inappropriate detention but about failure to assess and admit people who are in desperate need of it (and who are frequently requesting it.) As Baroness Meacher pointed out in the Lords Report Stage debate on an Alliance amendment to introduce a right to assessment,²⁰ a quarter of people who ask for help at present are turned away. The complainants are, however, more likely to be family and carers than patients themselves, and the duties of NHS Trusts are so ill-defined (hence the Alliance amendment) that judicial review is well-nigh impossible, so again this is an area which has been largely invisible in terms of caselaw.

Conveyance

All is not well, however, with the assessment-and-admission process itself, and ASWs have expressed particular concern about two main issues²¹, the first of which is the procedure for conveyance and admission to hospital. Having signed an application, the ASW then needs to secure a bed, suitable transport, and where necessary assistance from the police, which may also be needed during the assessment if violence is anticipated. None of this was a problem in 1959 – there were then too many beds, and the ambulance staff, police, and the ASW's predecessor, the Mental Welfare Officer, all worked for the same local authority – and it did not really become a problem until the late 1990s, when bed reductions began to bite and when the police and ambulance services, which had long since been detached from local government, began to tighten their priority criteria in pursuit of performance targets. As a result, in many places it can now take several weeks for an ASW to get a seriously-ill and perhaps dangerous patient into hospital.

This has highlighted the fact that no public body, other than the ASW, has any legal responsibility to ensure prompt and safe conveyance and admission. Even where the patient is an existing patient of the Trust which runs the community mental health service, and the Trust itself has requested the assessment, it assumes no legal responsibility until the patient has been accepted onto a hospital ward. Nor is the Primary Care Trust, which issues the ambulance contract, under a specific duty to ensure that adequate assistance is available, and the involvement of the police is purely voluntary over and above their normal duties to preserve public order. The local authority, as the ASW's employer, has a responsibility for their health and safety, but not for the conveyance process itself as this is placed by Section 6 on the ASW in person.

In addition, the application must be made out to a named hospital, and not infrequently ASWs arrive there with the patient only to be turned away, either because the promised bed has been taken or because the patient is judged to be too disturbed to be managed in that unit. If a bed is not immediately available in another hospital, allowing a fresh application to be completed on the spot, the authority to hold the patient lapses.

19 *Mental Health Review Tribunal, Secretariat Activity Report 2001-5*

20 *Hansard (HL) Debates 26/2/07 Column 1457*

21 *A detailed account of ASWs' concerns is set out within a Memorandum from the ASW Leads' Network to the House of Commons Committee on the Mental Health Bill (May 2007).*

As a result of the difficulties in getting assistance from the police it has also become apparent that rights of entry to private premises are not as clear as they had been assumed to be. The ASW would appear to have an inherent right to enter premises in order to carry out an assessment, since Section 129(1) makes it an offence to refuse access, but this right does not extend to the police attending to protect the ASW and the doctors since they are not “authorised under this Act” until an application has actually been signed, at which point the ASW can authorise them under Section 6(1) to assist with conveyance. Section 17 (1) (e) of the Police and Criminal Evidence Act 1984 does not appear to cover circumstances in which the possibility of violence has been anticipated but has not yet occurred.²² ASWs are understandably not happy to enter a house whilst the police wait outside until they can hear an assault actually being committed, and so many police forces are insisting that the ASW should apply for a warrant under Section 135(1) even where access is not being physically denied.

This creates yet further delay, and in turn raises the question as to whether it is lawful or proper for magistrates to issue a warrant in these circumstances. In addition, it has drawn attention to the criteria for the issue of such a warrant, which are derived from the comparable provisions in the Lunacy Act 1890 and the Mental Deficiency Act 1913 and which are that the patient “has been, or is being, ill-treated, neglected, or kept otherwise than under proper control, or being unable to care for himself is living alone.” Leaving aside the obsolete and stigmatising language (as one legal respondent to the Joint Scrutiny Committee on the 2004 Draft Bill put it, “we are not talking about dogs”)²³ this clearly does not cover all of the situations in which ASWs would need police protection, since many patients are neither being ill-treated or neglected nor are living alone.

BASW and the ASW National Leads’ Network (which represents the operational managers and trainers of ASWs) tabled a series of amendments on these issues in the Lords, but the government’s response was essentially to deny that problems existed in relation to the access powers, and to say that placing explicit responsibilities on the public bodies in respect of the conveyance process would make no difference in practice – or to put it another way, that it would not increase the supply of beds or cause police or ambulance services to modify priorities driven by government targets. This may be so, but it is still invidious that the personal responsibility – and the legal liability if anything goes wrong – rests on the ASW who has no effective control over any of the resources needed.

Assessment

The greatest concern of ASWs, however, has been about the assessment process. Many have been concerned about the extension of the ASW role to include health professionals (who will mostly be nurses), and whether they will be able as AMHPs to operate from the distinct social perspective of the ASW and to resist pressure from medical colleagues and their employing Trust, but the advanced age-profile of the ASW workforce and the problems being experienced by local authorities in maintaining numbers are such that it has been difficult to make a credible case against the government’s proposals, insofar as they are necessary to maintain the service.

In addition, as David Hewitt pointed out in a paper in this journal in November 2005,²⁴ the AMHP may already have arrived, at least to some extent. 40% of ASWs are already seconded to or in a few cases

22 Entry is allowed under this section only “for the purpose of saving life or limb or preventing serious damage to property”

23 Memorandum from IMHL and Peter Edwards Law, Ev 1118 para 4.4

24 Hewitt, D. *An Inconvenient Mirror - do we already have the next Mental Health Act?* *Journal of Mental Health Law Edition* 13 November 2005

directly employed by Mental Health Trusts (and seconded back to the local authority when on ASW duties),²⁵ and their employment by the Trusts will eventually become the norm, with newly-qualified social workers going straight into the Trusts and eventually acquiring the status of ASW/AMHP without any working experience within local authorities. The concern is, therefore, not that the revised Act would create a completely new situation, but that it might exacerbate problems which already exist.

There are basically two ways of conceptualising the assessment process, in which the patient is interviewed by two doctors and an ASW who then makes an application “founded on the medical recommendations.” One is to regard it as an explicitly quasi-judicial process, the other to see it as a multi-disciplinary decision by the clinical team as to the best way to manage and treat its patient. These two views are bound to be incompatible, since good multi-disciplinary team practice requires decisions to be taken where possible by professionals who know the patient well, have a close working relationship with one another, and share common perspectives, whereas a quasi-judicial process requires at least the body making the final decision (which in this case is the ASW) to be impartial and disinterested, and in particular to have no connection with the detaining authority.

The quasi-judicial view would appear to make the most sense from a human rights standpoint. The power of the three assessors is, after all, enormous. If a patient is detained from the outset under Section 3 (and this is so in about 28% of all cases)²⁶ they can be held for up to six months, given medication against their will for three months before they are entitled to a second opinion, and, if they appeal, cannot expect a hearing in under six weeks.

When I first acted under the 1959 Act in 1971, most assessments would have reached a quasi-judicial standard, since it was often the case that the three assessors – usually the G.P., the consultant from the (often distant) hospital, and the Mental Welfare Officer (MWO) from the local authority – had never even met one another, and the latter two had frequently not met the patient. There was, therefore, no danger of collusion between colleagues, and no doubt whatever that there was at least an element of impartiality, and that the MWO was not beholden to the detaining body.

The corollary was that common perspectives were often markedly absent, and there was no sense in which the assessors constituted a multi-disciplinary team. However, since then, practice has steadily evolved in that direction, and this trend has gathered pace in recent years with the development of joint community mental health teams and most recently with the secondment of ASWs to Trusts. It is quite likely now that the psychiatrist and ASW will be close colleagues in the same team, and that the latter will be accountable in their non-statutory role to a manager employed by the Trust. In addition, it is likely that they will both know the patient well, and that they may have been working for weeks to contain a crisis before a team decision is made to invoke the Act.

The psychiatrist and ASW in this situation now form a very powerful partnership to which the second doctors are an increasingly weak counterbalance. Since the introduction of the new G.P. contracts in 2004, they are much less likely to be the patient’s G.P., and although most will be approved under Section 12 of the Act as having psychiatric experience, they will rarely be psychiatrists of consultant status. Bearing in mind also that they are called out by the ASW and for a very generous fee, there is little incentive for them to challenge the collective view of the multi-disciplinary team, and as Richard Jones

25 See footnote 10 above

26 See footnote 2 above

points out in the foreword to the Tenth Edition of the Mental Health Act Manual²⁷, research has shown that this is a rare event. If the doctor is the patient's own G.P., they may arguably have more standing because of their continuing responsibility for the patient, but where the patient has been receiving support from a community team it is also arguable that the G.P. is a *de facto* member of that team, and a party to its collective decision-making.

The government's approach

The government's view in 1999²⁸ appeared to be that this process was no longer human-rights compliant and that the initial decision should therefore be confirmed very quickly by a tribunal, but it now appears to have forgotten this and seems quite happy for practice to slide even further away from a quasi-judicial standard, in order not to impede the development of integrated community services. The draft Code of Practice invites local authorities, if they so wish, "to enter into arrangements with the Mental Health Trust to provide the AMHP service on their behalf"²⁹ (i.e. to place *de facto* control of a supposedly-independent service in the hands of the detaining authority), and the Minister, Baroness Royall, stated in the Lords that "one of the advantages in broadening the professional groups who can become AMHPs is that it will be easier for Crisis Resolution and Home Treatment Services carrying out an urgent assessment to progress that to a MHA assessment without having to involve a professional from outside the team."³⁰ Many ASWs have expressed concern about the decision-making processes within the new Crisis Teams, which, as the number of ASWs has remained static as community services generally have expanded, often at present do not contain an ASW³¹, but it seems clear that the government does not want independent outsiders intruding on those processes and asking awkward questions.

The government's response to concerns about the independence of the AMHPs has been, first of all, to state in the Bill that (whilst unlike ASWs they need not be officers of the local authority) they will be acting "on the local authority's behalf." On the face of it this is reassuring; however, it does raise the question as to how meaningful this will be if the authority in turn contracts with the detaining Trust to run the AMHP service 'on its behalf'. On whose behalf will the AMHPs really be acting?

It also, albeit unintentionally, appears to compromise the AMHP's independence from the local authority when making a decision under the Act. ASWs at present do not assess under Section 13 "on behalf of the local authority" – they are appointed by it, must be officers of it, and can be directed by it to undertake the assessment, but once the assessment starts they act as an independent public authority, with personal liability. The government's view is that the Bill makes it clear that AMHPs are to be "independent professionals", and that the new phraseology does not therefore alter the current precedent; however, the concept of an independent professional is derived from NHS practice, where doctors in particular act on behalf of their employing Trust whilst making independent clinical and legal decisions, and it is foreign

27 Page vi, *Mental Health Act Manual (10th edition)* (2006) (Sweet & Maxwell), citing 'Performing the Act: A Quantitative Study of the Process of Mental Health Act Assessments – Final Report to the Department of Health' Alan Quirk et al (March 2000).

28 'Reform of the Mental Health 1983 – Proposals for Consultation' (the Green Paper) (Department of Health) (November 1999).

29 Mental Health Bill 2006, Draft Illustrative Code of Practice 1A 10 page 13

30 Hansard (HL) Debates 17/1/07 Column 749

31 *The Adults of Working Age Mental Health Service Mapping Exercise* (Durham University) showed that in 2004 nurses outnumbered social workers by about 2.6 to 1 in community mental health services overall, but by about 5 to 1 in the new Crisis Resolution Teams. Since these teams were then in their infancy, this imbalance is likely to have increased substantially with subsequent growth

to local government where all officers of whatever professional status (unless, like ASWs, they have a parallel legal existence) ultimately have to do as their chief officer or the political leadership tells them.

Secondly, in the same vein the government is saying that the independence of the AMHPs will not be compromised if they are Trust employees or are being managed by the Trust, since this will derive from their professionalism, and their training for the role will ensure that they will always act in an independent way. The simplest way of grasping the unreality of this is to consider the worst-case scenario (which is by no means unlikely) - where a relatively junior nurse, ambitious for promotion and new to the AMHP role, disagrees with a recommendation from the consultant psychiatrist in her team who is also the Trust's Medical Director. Experienced ASWs not infrequently find themselves in this sort of situation, and it can be very uncomfortable, but they do (or did until recently) have the security that their career prospects are not dependent on the Trust. And the training will be based on the existing ASW programmes, which last just 600 hours over 6 months³². It is hardly surprising that the Joint Committee on Human Rights concluded, in respect of the making of a CTO, that due to the concerns about their independence from the psychiatrist "we do not consider that the need to obtain the AMHP's agreement represents a significant safeguard."³³

A lack of human-rights compliance?

If this view is accepted, it would be difficult to argue that the decision-making process under Sections 2, 3 and 4 is human-rights compliant, given that it is the AMHP who will be making the final decision. The government would no doubt say that the minimum requirement is met by the need to obtain a recommendation from a second doctor, but for the reasons already given, this is likely to be a protection only against the most blatant abuses of professional authority; and it would also be difficult for the government to explain why it is setting a much higher test of impartiality for the less-draconian 'Bournewood' powers, the regulations for which will stipulate that the 'best interests' assessor, the equivalent of the AMHP, must not be involved in the care of the person they are assessing, in decisions about their care, or be on the staff of the hospital or care provider which will be the detaining authority.³⁴

It would, however, neither be practicable nor in the patient's best interests to insist on a strict quasi-judicial process. Decisions must frequently be made at very short notice, and often out-of-hours, and in many rural districts the three assessors will often be the only qualified professionals available; the Bournewood procedures, by contrast, are unlikely to be applied in an emergency. In addition, it is not in the interest of the patient for the assessors to reach a conclusion which is legally immaculate but ill-informed, and it can be very difficult for a complete outsider, in the very limited time which is often available, to assimilate all the information required to make a sound and reasonable decision. There does, therefore, need to be a balance between disinterestedness on the one hand, and the in-depth knowledge of the circumstances and of the options available which is only possessed by the professionals who have been closely involved with the patient.

Several local authorities do nevertheless prohibit their ASWs from acting in respect of their own clients or those of their own team, but others argue that an ASW from outside the team is much less likely to be able to influence the thinking of the psychiatrist in the team, who is still very much the most powerful player in the whole process. However, this argument makes more sense in respect of the present body of

32 'Assuring Quality for Mental Health Social Work' Central Council for Education and Training in Social Work (CCETSW) (2000).

33 Joint Committee on Human Rights para 56

34 *The Bournewood Safeguards – Draft Illustrative Guidance, December 2006 para 97*

ASWs, who are mostly very long-serving and who still have at least one foot in the local authority structure, than for the forthcoming generation of NHS-bred AMHPs.

A reasonable balance

BASW and the ASW Leads' Network believe that a reasonable balance would be struck if, first of all, the present arbitrary rules in Section 12 governing conflicts of interest between assessors were replaced by a more flexible regulation-based approach, based around a set of principles which would place the onus on the assessors to recognise when it was not appropriate for any two or three of them to act together. The present rules are mainly concerned with the relationship between the two doctors and take little heed of the possibility of collusion between the ASW and a doctor, that being far less likely in 1959. A principle-based formula would make it much easier for an AMHP to decline to act when they felt themselves to be in a position where they were vulnerable to improper influence or to accusations of bias. The first step towards this has now been achieved in that the government has accepted an amendment³⁵ which creates the regulation-making power, although discussions have yet to take place as to the content of the regulations.

Secondly, BASW and the ASW Leads' Network believe that the independence of AMHPs employed by the Trusts would be sufficiently protected if the local authorities were required to retain direct responsibility for those management functions, such as performance monitoring, capacity and disciplinary issues, complaints, dispute resolution, and setting of local practice standards and guidelines, which if delegated to the Trust would severely compromise independence. In addition, legal support to AMHPs should definitely *not* come from the Trust's lawyers. This would not prevent delegation to the Trusts of the operational control of the AMHP service – in other words, deciding how many there should be, and who goes where – which is better done by the body which has overall responsibility for the management of the local mental health service.

Resistance to this, however, is likely to come as much from the local authorities as from central government or the Trusts. Whilst the local authorities' responsibilities for the training and approval of AMHPs will be set out in regulations, the government and the local authority bodies were united in opposition to the amendment proposed which would have required the management arrangements to be subject to the same central prescription. Local discretion is now the watchword; however, it is not appropriate for arrangements which impinge on the liberty of the individual to be left, as the Minister put it, to "local practice,"³⁶ even when subject to government guidance, especially given the strong financial incentive there will be for local authorities to transfer their AMHP services lock, stock and barrel to the Trusts along with the rest of their mental health services rather than retain the managers in-house. It does, however, appear that the government is willing to issue detailed guidance, and it has fallback powers under Section 7 of the Local Authority (Social Services) Act 1970 to issue directions in the case of widespread non-compliance. In addition, the local authorities' lawyers may well point out to them that, since AMHPs will be 'acting on their behalf', it would not be legally prudent to surrender all effective control over them.

35 *Hansard (HL) Debates 26/2/07 Column 1392*

36 *Hansard (HL) Debates 15/1/07 Column 540*

Conclusion

BASW and the ASW Leads' Network are pleased that, by tabling nine amendments in the Lords, they have at least drawn attention to the processes of civil detention and admission to hospital which have hitherto been largely overlooked. However, the government's responses have tended to confirm that it has limited interest in retaining the independence of the present ASW role and that it is prepared to sacrifice it in the interests of ensuring the smooth operation of the new community services, prioritising collective decision-making over quasi-judicial principle.

At the same time, it is assuming that the existing ASWs will be happy to transfer to the new AMHP role regardless of this loss of status, and the impression is that it regards them essentially as useful administrative functionaries, oilers of wheels rather than guardians of rights, who will continue to operate the civil processes without complaint as indeed they have very largely done since 1983. However, it is also assuming that, as the current long-serving ASWs retire, significant numbers of health professionals will be willing to step into their shoes; although the Regulatory Impact Assessment recognises that it will take time to introduce them, it forecasts that by 2012/13 they will make up 15 % of the AMHP workforce.³⁷

The perseverance of the existing ASW workforce cannot, however, be taken for granted, given that many ASWs are within sight of retirement and have attributes which are highly valued elsewhere in social care. Nor can it be assumed that health professionals will be queuing up to take their places; they have shown very little enthusiasm so far, which is hardly surprising in view of the difficulties which they observe their ASW colleagues to be experiencing. In particular, the arrangements for assessment and conveyance of potentially-violent patients, dependent as they are on unreliable police and ambulance support, would not be regarded as a "safe scheme of work" by NHS health-and-safety standards. The government may at present be complacent and dismissive of these difficulties, but ultimately it has no choice but to address them if it wishes to ensure that the civil procedures of the amended Act will continue to be administered as effectively by AMHPs as they have been by ASWs for the past 24 years.

³⁷ *Regulatory Impact Assessment Annex A, Table A3 page 54*