

# Responses to the Draft Mental Health Bill

## *Law Society's Response to the Draft Mental Health Bill*

### **Introduction**

Mental illness and mental incapacity are two of the last great social taboos and that is why it is so important for people to have enough time to discuss and understand the implications of the Government's Mental Health Bill. This Bill is not now in the current legislative timetable, however, Ministers have indicated their commitment to legislative reform, and soon.

### **Widening the criteria for detention**

The Bill appears to have been drafted in response to public concern about rare high profile cases where individuals suffering from severe personality disorders have committed serious crimes. Unfortunately, there are many dangerous people on the streets, only a small minority of whom suffer from mental illness. Many serious crimes are committed by people under the influence of alcohol but no-one suggests that anyone calling at their local pub for a drink is a potential criminal. Categorising people suffering from mental illness by way of potential risk is equally inappropriate.

The impression that streets will be made safer by this legislation is a myth. The Richardson Committee which advised the Government on the scope of new legislation, recommended the wider definition of mental illness and greater powers of detention only if there was a reciprocal right on the part of the patient to receive appropriate treatment. Psychiatric services have long been under-funded, many hospitals have been closed down. There are currently 400 consultant psychiatrist posts vacant nation-wide. The Government have announced increased funding to implement the proposals should the Bill be enacted but it is likely to be woefully inadequate to provide the services for all the people detained under the new definition. That, presumably, is the reason why the element of reciprocity stressed by the Richardson Committee is absent from the Bill; the Government does not want to create a statutory right to services it cannot provide.

The Royal College of Psychiatrists, one of a number of organisations who are working with the Law Society and who have assisted in resisting this Bill, has reported such a level of concern amongst its members about proposed legislation that it predicts the number of consultant vacancies will rise to 600 if the Bill became enacted. People with mental illness, many of whom have already been failed by the "care in the community" scheme, will be less, rather than more likely to engage with psychiatric services if the threshold to detention is lowered without the reciprocal guarantee of appropriate treatment. Disengaged from the services, their condition is likely to deteriorate and there will be more, not fewer, seriously ill people on the streets.

### **Human Rights Compliance**

Far from bringing the process further into line with human rights best practice, the Bill appears to create a range of possible new areas of challenge. The Bill only partially addresses the problem in

the case of *Wilkinson*<sup>1</sup> which is a treatment case brought under Articles 2, 3 and 8. The position of an individual who does not wish to comply with treatment and has mental capacity is still not clear under the Bill.

The Bill suggests that prisoners who are subject to compulsion should receive their treatment in prison. This gives rise to a possible challenge under Article 5. In *Aerts v Belgium*<sup>2</sup> the ECHR held that detention of someone in a hospital wing of a prison violated 5(1)(e). The new criteria allows a person to be detained even if they are “untreatable”. If the detention does not achieve its legitimate purpose, the compulsion is challengeable on the grounds of proportionality.

In relation to Article 6, the Bill also introduces a two tier tribunal system. Although this is largely welcomed by the Society, the impact of the introduction of this system does present practical problems. Firstly, in the recruitment of extra members for the tribunals. Secondly, in settling an appropriate venue for additional sessions. Thirdly, in the increased administrative workload. If these issues are not properly addressed, continued serious delays will occur. Delays in tribunals have already seriously prejudiced patients’ interests. The Bill puts additional stress on a system which is already in ‘meltdown’.

Further, current law and practice allows for a tribunal hearing on an assessment to detention to be held within 7 days whereas the proposals under the Bill state that a routine referral will take place within 28 days. The Bill therefore represents an erosion of existing rights.

The concept of a nominated person introduced by the Bill to replace what is currently the nearest relative allows a patient to have some choice over the person appointed. Under existing law this omission breaches Article 8 and this has been partially addressed under the new Bill. However, the new “nominated person” has no right to apply to have a detained person discharged, they have also lost the right to object to treatment on behalf of a patient.

### Lack of overarching principles

The Bill does not contain any overarching principle such as that in the Children Act 1989 which places the welfare of the child as being of paramount importance. This principle helps practitioners, judges and those advising, to keep in mind the main thrust of the legislation. Principles for mental health law are very important when dealing with vulnerable members of society. Principles which the Bill could contain are those of non-discrimination, self-determination and personal responsibility and most importantly the ‘least restrictive alternative’ principle. Only this way can we maintain the ethical standards required when considering depriving someone of their liberty for reasons of their health. The professions need overarching principles and ethical considerations. Law and psychiatry are very different disciplines each trying to apply their own principles in a manner so as not to cause injustice to the patient or to enhance their welfare. It is important to view “the relationship between law and psychiatry in terms of ethics since it is not only in relation to research that those who are inherently potentially less able to control their own destiny, such as many with mental disorders, who most merit scrupulous ethical investigation.... in spite of any apparent protection they may appear to receive from the law. ....It is not only

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1 *R (Wilkinson) v (1) Responsible Medical Officer (2) Broadmoor Hospital Authority (3) Mental Health Act Commission (4) Secretary of State* [202] CA 1 Weekly

*Law Report page 419*  
2 [1998] 29 EHRR page 50

psychiatry but also the law that is properly open to ethical scrutiny. Ethics is indeed above not only psychiatry but also the law".<sup>3</sup>

Therefore because of the differences between the two professions and the vulnerability of mental health patients, mental health law needs overarching principles and ethical considerations.

### **Interface with criminal law**

The need for an overview of the impact of the Bill becomes imperative when looked at in conjunction with the development of criminal law.

It is a widely held view that early diagnosis and treatment is more likely to prevent offending behaviour and that once a person becomes part of the criminal system, it is less likely that their mental health problems will be appropriately treated. This is why the Society supports early engagement. Whilst the Law Society is keen to put into perspective offending behaviour and mental illness, it should be noted that the media increasingly report cases where persons with a mental disorder and violent behaviour re-offend (this becomes particularly newsworthy when children are involved). Mental health issues and serious crime are inextricably linked.

The Government in their attempt to restore public confidence both in the criminal justice system and mental health have shifted their focus from one of rights to the individual to that of protecting "decent citizens" or "innocent members of the public". Use of this language polarises "decent society" whom it would appear are the victims of those who are "threat to society". There appears to be little acceptance that members of the public can be victims one day and defendants the next. This is the case especially with mental health problems. Such rhetoric is simplistic and divisive differentiating deserving citizens from the undeserving. The shift towards public protection can be seen in other areas of law, particularly the criminal justice system. The challenge to the Law Society is to alert the public to this shift and to examine the issues carefully. We need to ask on what policy grounds can such a development in mental health law be justified.

Public understanding of mental illness has come a long way in recent years. The Mental Health Bill which was proposed by the Government with its emphasis on risk reintroduced stigma to mental illness. If the Bill remains unchanged it will serve patients badly by eroding their rights and serve society badly by driving patients away from the treatment they need. This view is shared by all major interest groups dealing with mental illness.

The Law Society welcomes the withdrawal of this Bill from the legislative timetable and hopes the time can be used for constructive dialogue with a view to addressing the problems we have raised in this article.

### **The Law Society**

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3 Nigel Eastman, *Criminal Behaviour and Mental Health*, Volume 2 No. 1 2001 page 124

## *This Commentary is made on behalf of the Royal College of Psychiatrists in response to the Draft Mental Health Bill*

### **Introduction**

The Royal College of Psychiatrists is gravely concerned about the deleterious effects of the Government's Mental Health Bill upon patients' civil rights and the professional and public perception of the role of psychiatry. In addition it will seriously harm recruitment into a medical specialty which is already heavily under-recruited. The resulting damage to mental health services will make the Bill self-defeating in relation to its core objectives.

Before discussing this Bill it must be emphasised that the proper content of a Mental Health Act can only be determined after the passage of an Incapacity Act. The new Mental Health Act should be drafted with direct and explicit reference to the interface between that Act and an Incapacity Act. The lack of a 'joined-up approach' to legislation is very regrettable.

### **The Potentially Positive Aspects of the Bill:**

1. The use of Tribunals to authorise longer term compulsion is welcomed. However the number of hearings will increase substantially. This has implications for medically resourcing the clinical service in addition to the Tribunals and the Expert Panel. Also, the Courts, not just the Tribunals, will have access to the Expert Panel and this will increase the burden on doctors. Furthermore, given that the Tribunal is effectively a 'judicial' decision on 'the care plan' it is crucial that the patient's lawyer has an opportunity to cross-examine both the clinical supervisor and the Expert Panel doctor. This is made more important by the right of the patient to his/her own expert and it would be wrong for one to be questioned in the hearing and not the other. Given that increasing the numbers of psychiatrists is not possible, other than as a long term objective, more time given to legal work means less time with patients.
2. The right to independent advocacy is also welcomed, although there are concerns as to how the services are to be developed given the current available skills and resources.
3. We strongly support the importance of good quality information being available. There may well also be advantages in the monitoring system being part of a much larger organisation such as the Commission of Health Improvement (CHI). There are however particular issues pertaining to detained patients. CHI appears to focus on monitoring systems occurring in hospitals, as opposed to visiting individual patients. This must be addressed.

### **The Definitely Negative Aspects of the Bill:**

1. The absence of the Richardson Committee proposal for an Act based upon stated and incorporated principles.

### *Criteria for Compulsion*

2. The absence of a 'best interest test' in relation to patients posing no serious risk to others is likely, in some circumstances, to result in patient harm. In treating certain medical conditions, compulsion can be counter-therapeutic, namely where the essence of therapy is the acknowledgement of personal responsibility.
3. The absence of a requirement for 'therapeutic benefit' in relation to serious risk to others.
4. The requirement for a Trust to arrange an assessment for possible compulsion under the Act on request from anyone. It is clearly open to abuse by difficult neighbours or aggrieved partners. This is compounded by the lack of an independent applicant.
5. The breadth of the proposed criteria leading to compulsion. Patients suffering from multiple sclerosis, Parkinson's disease, learning disability or dependence on alcohol or nicotine, amongst many others are included. All of these are 'mental disorders' (in terms of the suggested definition) and all are susceptible to 'medical treatment'. The broad criteria, combined with lack of exclusions make it difficult to imagine many circumstances where a patient who suffered from 'mental disorder' for which there was 'appropriate medical treatment available' would not potentially be subject to compulsion. This is likely to be a particular problem for people with long-term mental health problems such as learning disability, dementia or personality disorder, who could be subject to compulsion at any time. There is not even a clear requirement in relation to severity of the disorder given the absence of an equivalent of the 'nature or degree' to require 'admission to hospital' of the current Act.
6. The lack of clinician discretion as to whether or not to use compulsion, combined with the broad definition of mental disorder, loose criteria and lack of exclusions means there is an 'automatic chain-reaction' which is initiated by a request to the Trust for an assessment and 'inevitably' ends with compulsion under the Act. The conditions for assessment being met leads to a duty to carry out such an assessment. If the conditions continue to be met then there is a duty to apply to the Tribunal for an order, either for the patient to be treated compulsorily in hospital or as a non-residential patient. If the conditions are still met then the Tribunal must make the order.

Much has been made of occasions when the 1983 Act has not been applied when it might have been, sometimes by virtue of misunderstanding of the legal effect of the exclusion criteria. This may have been the case particularly in relation to patients with dual diagnosis, or patients with drug induced psychosis. However, on many occasions where drug abusing patients have not been admitted, albeit when legally they could have been, this is likely to have been the result of inadequate physical resources (locked wards) and the absence of nursing staff sufficiently trained in dealing with difficult and sometimes violent patients. The proposed 'solution' to this problem in the Bill will merely substitute a different problem for the current one. Hence, the combination of lack of exclusions and loosely defined legal criteria for compulsion suggest that there is likely to be frequent medically and socially inappropriate use of the new Act, especially in the context of a 'blame culture'. Yet it will remain the case that in-patient services will continue to be so stretched and poorly resourced as to continue to make it inappropriate or dangerous to admit patients exhibiting violence alongside those who are (for example) profoundly depressed or elderly.

We would very much support the Scottish proposal of 'impaired decision making' as the core criterion for compulsion.

7. The term 'medical treatment' is defined far too broadly particularly in light of the looseness of the criteria.

### *Powers of Discharge*

8. It is unacceptable for clinicians to lose the absolute right to discharge civilly detained or compelled patients who they believe should no longer be detained or compelled. It is hard to imagine the effect on medical care in circumstances when neither the patient nor their doctor believes the patient should be in hospital, or subject to compulsion, and yet discharge is prevented, despite the patient having committed no offence.
9. For civilly detained patients under the current Mental Health Act, there are four possible routes for discharge, whereas the draft Bill will potentially reduce these to one. This represents a serious diminution of civil liberties.
10. The exclusion of Clause 6 (4) ('the treatment cannot be provided unless he is subject to the...Act') in relation to those who present a 'substantial risk of serious harm to other persons', clearly contravenes the core notion of using 'the least restrictive alternative'.

### *Data Sharing*

11. The proposals in relation to sharing information will discourage people from seeking assistance and is likely to do more harm than good. This may particularly be the case if they take illicit drugs, given their knowledge that the doctor treating them would have a duty to consider reporting them to the police. Clear guidance on sharing information when there is a serious risk to others is given by the General Medical Council and supported by the courts.

### *Cost Implications*

12. The workforce and financial cost implications of the Bill will be considerable. There is therefore a high risk that, without major additional resources, the delivery of mental health services will suffer as a result of implementation of the Bill. This risks defeating many of the Government's intended purposes of the Bill, including enhancing public protection. We believe it is almost certain that the Bill will prove unworkable.
13. It is important to note that members of the College work in the other jurisdictions within the UK. The Scottish legislature first passed incapacity legislation and has then proposed a mental health bill which has been universally welcomed. It is highly likely that there will be patients who will be subject to compulsion in one jurisdiction but not in the other. Gretna Green may again become a place to which to run.

## **Conclusion**

This Bill was introduced in response to a belief that drafting a new Mental Health Act in this way will protect the public from the (misconceived) dangerousness of the mentally ill. Even if this is a legitimate aim, the Government's approach is fundamentally in error, in that it is based upon 'individual case scenarios' rather than properly upon an 'aggregate public health model'. The Government assumes that, because there may be individual cases identified where the availability of the powers proposed in the Bill would be likely to produce increased public protection therefore the overall effect of the Bill will be to increase public safety. This reasoning is erroneous. Rather, it is necessary to attempt to predict the overall effect upon patients and services in the aggregate of introducing any new legislation. Hence, if patients overall are driven away from services by the fear of 'draconian legal powers over them', if the functioning of mental health services is distorted away from 'best practice', and if, in the long term, the practice of psychiatry is stigmatised as being too closely linked with public protection, so that medical recruitment into the specialty is further reduced, then overall the effect of such new law will be to reduce public protection and national mental health.

The College believes that the Draft Bill will, if enacted, result in poorer mental health care and reduced public safety, both being at the further expense of increased stigmatisation of mental illness, stigmatisation within medicine of psychiatry as a specialty and erosion of patients' civil rights. A Mental Health Act must be both consistent with the nature of services to which it relates and command support and respect from those directly concerned with its use. Neither condition is satisfied by the Draft Bill.

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**Consultant Psychiatrist, Leeds Community and Mental Health Service (Teaching) NHS Trust  
RCPsych lead on mental health law reform.**

## Liberty's\* Response to the Draft Mental Health Bill

### Introduction

1. The representations made in this paper begin with a consideration of the main points Liberty wishes to address, and concludes with further significant areas, among which are some of the points on which views have been specifically requested by the Consultation Document<sup>1</sup>.
2. Before the final draft of the Mental Health Bill, Liberty made a number of representations as to the proposed content of that Bill. Whilst it welcomes the expressed intention to enact a measure more compliant with the obligations of the ECHR, Liberty is disappointed to note that a number of the matters that go to the heart of civil liberties have not been satisfactorily addressed in the current Draft Bill.
3. Liberty has previously made submissions to the Expert Committee chaired by Professor Genevra Richardson in 1999<sup>2</sup>. We believe that there are matters addressed therein that still remain to be dealt with in manner consistent with the Government's obligations to patients and potential patients of the system.
4. The current main areas for Liberty's particular concern are the following:
  - The definition of mental disorder
  - Dangerous people with Severe Personality Disorder
  - The non-statutory status of the Code of Practice
  - The incapacitated patient
  - Compulsory treatment in the community
  - Scope of Review Tribunals
  - Data Sharing

### The Definition of Mental Disorder

5. Liberty is concerned to note that the Bill has chosen a broad and unqualified definition of the main criterion for compulsory detention. The term "mental disorder", standing alone replaces the more complex definitions of the 1983 Act, which was generally accepted to be outdated for various good reasons.
6. The concern arises out of the fact that there is no statutory definition of the phrase mental disorder save for the following broad statement in clause 2(6) "*Mental disorder means any disability or disorder of mind or brain which results in an impairment or disturbance of mental functioning...*". There are no protections in the form of exclusions for those suffering from, for example, alcohol or drug dependency. In fact the definition is drawn so broadly that minor

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\* Liberty (The National Council for Civil Liberties) is one of the UK's leading civil liberties and human rights organisations. Liberty works to promote human rights and protect civil liberties through a combination of test case litigation, lobbying, campaigning and research.

It is the largest organisation of its kind in Europe and is democratically run.

1 CM5538III

2 [www.liberty-human-rights.org.uk](http://www.liberty-human-rights.org.uk)

disorders such as mild depressions or learning disabilities would fall into the definition in clause 2(6). Liberty is very concerned that there are no protections from the abuse of power on the face of the statute. The Explanatory Notes to the Bill explain that further materials and diagnostic criteria will be referred to in the Code of Practice. However, Liberty notes with concern that the Code of Practice has no statutory force.<sup>3</sup>

7. We believe the criteria by reference to which a person may be deprived of his or her liberty should be set out in, at the least, secondary legislation. It is clear from the face of Article 5 and from the earliest Strasbourg cases<sup>4</sup> that detention must be “according to the law”; that law must be readily ascertainable and precise. Liberty queries whether that can properly be said of the current Bill as structured. As drafted the Act lays itself open to abuse and for the criteria for detention to be changed without the democratic safeguards of legislation.
8. The reason for the change of format is said<sup>5</sup> to be the fact that Clinicians have misunderstood the old Act, not applying the Act to those with mental disorder overlaid with, for example, substance abuse. The remedy lies in education, or in more precise drafting. It does not lie in replacing the protections of the old Act with general, undefined terms, which are open to abuse.

### **Dangerous people with Severe Personality Disorder**

9. Liberty recognises that the Government has expressed<sup>6</sup> its intention to include within the scope of the new Act those with untreatable psychopathic disorder, sometimes referred to as dangerous people with severe personality disorder or DSPDs. That is to say, that it intends to change the definition of treatability as to effectively remove it as a criterion for admission for treatment for this class of person. It is accepted that the treatability criterion does not find a clear place in the Strasbourg jurisprudence as it has developed in the Strasbourg case law. We also recognise that the challenge mounted in the Scottish jurisdiction<sup>7</sup> to provisions having similar effect, arguing principles of ECHR law, failed in the Privy Council on a devolution issue appeal. We nonetheless contend that the compulsory detention within a hospital (and thus, therapeutic) regime, of those who can receive no therapeutic benefit from that regime is wrong.
10. Liberty believes there are cogent arguments against the Privy Council’s conclusion that it is neither arbitrary nor disproportionate to detain a person in hospital who cannot be treated. Detention in the hospital system without treatment is mere containment. In *Ashingdane v United Kingdom* (1985) 7 EHRR 528 the court accepted there should be some relationship between the place of detention and the reasons for detention under Article 5(1)(e): there must exist suitable conditions or treatment to justify the detention.<sup>8</sup> It is suggested that hospital detention is unsuitable for a person who cannot benefit from treatment. Irrespective of the potential benefits to public safety of containment of such persons, it is inappropriate for any such person to be, effectively, imprisoned within the hospital regime. It is also an

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3 See below

4 *In Winterwerp v The Netherlands* (1979) 2 EHRR 387, 402-403 para 39 - 45 part of the reasoning included the proposition that the law must be sufficiently accessible to the individual and sufficiently precise for him to for see the consequences for himself, in order to be lawful.

5 *In Mental Health Bill, Consultation Document Cm 5538 III*

6 *Draft Mental Health Bill Department of Health 2002 Annexe A paragraph 4*

7 *Karl Anderson and Ors v The Scottish Ministers and Ors PC* ( 31st July 2000) [2001] UKPC D5

8 See also *Guzzardi v Italy* 3 EHRR 367

inappropriate use of hospitals and National Health Service resources. There are shortages of properly trained health professionals and secure beds in the NHS.

- 11 Liberty understands that the number of persons within the definition of dangerous personality disorder is around only 300 – 600 in England and Wales<sup>9</sup>. We contend that the disproportionate publicity attaching to the comparatively small number of incidents caused by this minute segment of the population has unduly influenced policy. Liberty acknowledges that the public interest in safety must also be an important consideration. However, in this instance, it is suggested that the balance between the interests of the public and those of the individual is wrong.
12. Hospital is an inappropriate venue for the containment of offenders who cannot be treated, and even more inappropriate for *potential* offenders who cannot be treated.

### The Code of Practice

13. There were cogent submissions made regarding the Code of Practice to the Expert Committee<sup>10</sup> to the effect that the Code should have statutory force. The Committee decided, on balance, after careful consideration, that the Code should not have statutory force. It urged, however, that there should be a statutory presumption of compliance expressed in the Draft Bill.<sup>11</sup> There is none.
14. Liberty is concerned at these omissions. Indeed, it is our contention that the Code must have statutory force. The Bill has expressly been drafted with the purpose of fulfilling the Government's obligations under the ECHR. This is presumably not least because the circumstances and treatment of the mentally disordered expose them to a risk of breaches of their human rights (*Keenan v UK (2001)* 33 ECHR 38 at paras 110 and 112, *X v UK* Appn. No. 6840/74 followed by the DHSS Review of Special Hospitals Seclusion Procedures). The Code's express purpose is to set down the principles that underlie the Bill, and give guidance to those discharging functions under the Bill. It is plainly at the Bill's heart, and following a recommendation of the Expert Committee, reference to it is placed in clause 1 of the Bill.
15. The Code's ambit includes the care and treatment of persons subject to the Bill, for instance, their seclusion and restraint, or their compulsory treatment – all areas in which their fundamental human rights are engaged. However, as stated above, the Bill as currently drafted does not impose any obligation on those who compulsorily detain or treat the mentally disordered under the Bill to comply with the Code, or contain any presumption of compliance: despite the fact that it is intended as a safeguard against breaches of their human rights.
16. The same deficiency in the present Act has recently been exposed in the case of *R (Munjaz) v Ashworth Hospital and others (unreported, 5 July 2002, Sullivan J)*. In essence, the UK Government claims to safeguard the human rights of those subject to the present Act and the Bill by a Code which detaining authorities and professionals may ignore at their discretion.

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9 Government Consultation Paper *Managing Dangerous People with Severe Personality Disorder* [ref]

*Mental Health Act 1983, November 1999 (the "Richardson Report")*

10 in *Report of the Expert Committee; review of the*

11 *Richardson report paragraph 2.30*

This code cannot be relied upon by patients in legal proceedings because it has no greater force than merely non-statutory Guidance.

17. Liberty understands a number of the considerations regarded by the Richardson Report as essential to the construction of a humanitarian and modern mental health statute, are relegated to this non-statutory document. Thus reference to consensual care, autonomy, reciprocity, respect for diversity etc<sup>12</sup> will only be made in the Code.
18. It is suggested that the unsatisfactory position of the Code reflects the character of the Draft Bill, which is wholly different from the character of the legislation proposed by the Expert Committee. In essence, the patient focused Richardson Report is being replaced by a bill where presumed public safety considerations are dominant.<sup>13</sup>
19. Liberty submits that the only way in which the Bill's avowed intention to fulfil obligations to individuals, particularly under Articles 2, 3, 5, 6 and 8 ECHR, is to give the Code statutory force either under the Bill or by the making of a Direction by the Secretary of State.

### **The Incapacitated Patient**

20. The proposal that incapable patients should benefit from statutory safeguards is plainly necessary. However, Liberty is concerned that the positive potential of this part of the Bill is undermined by the absence of a statutory definition of incapacity. If it is proposed that the Code should supply the definition, the comments made above in relation to the Code are repeated. Liberty submits that the definition put forward by the Law Commission (in *Who Decides?*<sup>14</sup>) should be adopted and included in the Bill to promote certainty in the care and treatment of this group of patients newly included within the statutory framework.
21. Parliament should further consider whether, having made legislative provision in respect of this aspect of incapable adult's lives, it should enact the Mental Incapacity Bill so that decisions may be made about other areas such as social care, housing and all medical treatment, not just for mental disorder.

### **Compulsory Treatment in the Community**

22. Liberty wishes to encourage a cautious approach to the delivery of compulsory medical treatment in the community. We are pleased to see that there are no provisions which allow the compulsory treatment of a person in their own home. Liberty is nonetheless concerned that compelling the capacitated to accept medication with the threat of confinement on failure (clause 117) is likely to discourage co-operation; and undermine if not destroy the therapeutic relationship in the community. This approach runs the risk of alienating and isolating the patients it is intended to serve, since collaborative relationships are generally considered to be the most beneficial. An additional element of coercion in the relationship between carers and patients will not assist the provision of care, or, ultimately, the protection of the public.
23. It has been suggested<sup>15</sup> that compulsory treatment in the community should be coupled with

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12 *see further the critique of the Green Paper by Jill Peay in "Reform of the Mental Act 1983: Squandering an Opportunity"*

13 *See further in this connection the comments upon*

*DSPDs above*

14 *CM 8303*

15 *by The Sainsbury Centre for Mental Health, among others*

the provision of intensive community support services. If adequate care is absent the powers are open to abuse. Liberty supports the suggestion that assertive outreach is a necessity if the proposals are to work to the benefit of patients in the community, and draws attention to the significant negative response it understands to have been received from professionals. However, we also recognise that there is also informed support for the principle<sup>16</sup> of such compulsion if adequately supported within the community.

24. Liberty wishes to emphasise the necessity for a suitable location for the administration of any treatment that was not carried out in a hospital setting; an issue allied to the provision of sufficient community support generally for those discharged from hospital care.

### **The Scope of New Review Tribunals**

25. There is provision in the Bill for a single member to sit and determine some matters brought to the Tribunal. While it may be appropriate for some matters to be dealt with by a Single Member, it is suggested that fairness requires that such Single Member sittings should take place only with the consent of the patient concerned, and that he should be entitled to request a full sitting of the Tribunal.
26. While the creation of a right of appeal to a specialist body is welcomed by Liberty, it is concerned that this right is limited to appeal on a point of law. This has two adverse consequences:
  - a. The limitation on the right of appeal undermines the positive effect of the creation of the right and the appeal body, namely that of determination by an expert body with specific experience of the area. Many issues before Mental Health Tribunals will turn upon difficult clinical questions of diagnosis, treatment and care. To deal with these issues, there should be a right of appeal, with leave of the chairman or the Tribunal.
  - b. This will involve preliminary consideration of cases that are likely to require adjudication by a higher court. In recent years a number of vital issues in the area of mental health (particularly since the coming into force of the ECHR) have required adjudication by the House of Lords and Court of Appeal. Such decisions, e.g. *Bournewood*, have had consequences for very many patients. A requirement that such issues must first be determined by the Appeal Tribunal is undesirable, resulting in the prolonging of potentially unlawful detention or treatment of many. Leapfrog provisions exist in other statutes where delay is to be avoided in order to protect both individual human rights and the public interest.<sup>17</sup>
  - c. Liberty is further concerned that the right of appeal may only be exercised by the chair of the Mental Health Tribunal, and that there is apparently no mechanism for challenging this refusal of appeal save by judicial review of his decision.

### **Data Sharing**

27. Although some information sharing may be necessary for public protection, Liberty is concerned that information should only be shared with individuals or public authorities when it is necessary to do so. It is vital that there is clear Government guidance on this issue

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<sup>16</sup> *National Schizophrenia Fellowship*

<sup>17</sup> *Compare the Immigration Act materials*

since there are currently a wide variety of local and inter agency practices which lack consistency.

28. Particular care should be exercised in considering whether victims, or relatives of victims, of mentally disordered patients should be informed of their discharge, or progress towards discharge. The giving of such information often comes close to providing information about the medical condition or treatment of the patient to others when no other individuals would have their medical confidentiality broken in this way. Liberty believes that extreme caution should be exercised when passing out information to ensure that patient confidentiality is protected to as great an extent as possible. Further, any guidance on the provision of information to victims or their relatives should require those considering the giving of information to have regard to the effect of the giving of information on the mental state of the patient, and to the risk that he may be subject to reprisals or other negative consequences.

**Liberty would like to acknowledge the authors of this article Alison Foster QC and Fenella Morris, both of Chambers of Nigel Pleming QC, 39 Essex Street, London WC2R 3AT**

## *Response by Guy Otten, MHRT Regional Chair for Trent, Yorkshire and Northern Region, to the Draft Mental Health Bill*

### **Introduction**

I support the broad aims of the draft Mental Health Bill. It is time to modernise the law to reflect the community focus of treatment for the mentally ill, and to improve the law's support for the work being done in the National Health Service, Social Services and private sector to help mentally ill people.

In particular I support the introduction of a measure of compulsion in the community, as the way of using the least restriction on liberty consistent with the need to help the patient recover and maintain his/her recovery. I also support the new 'Gateway' system for sectioning, the Nearest Relative reform, the strengthening of the protection for the Bournwood patients and children, and the greater provision for DSPD patients. However, I have some reservations and concerns over the proposed Bill; some of which go beyond the Consultation areas.

The following remarks focus on some of the issues that strike me as either particularly controversial or problematic; they do not constitute the views of the Mental Health Review Tribunal service or of the other Regional Chairs or Liaison Judge.

### **The proposed Mental Health Tribunals (MHT)**

#### ***Resourcing Issues***

The new Mental Health Tribunal will be busier, and will therefore cost more than the existing Mental Health Review Tribunal, and must be resourced properly.

The MHRT has for years suffered persistent and serious inadequacy of funding. I look to a permanent Government commitment to fund the MHT (and MHAT) fully, so that delays are a thing of the past, (which means more staff and more members) and members are valued by proper mileage rates, and annually reviewed and increased fees which are automatically linked to an appropriate scale. Also, full advantage should be taken of technology, for example, by means of a website (to promote openness and a better understanding of what MHT will do and expect from users), and the provision to all Tribunals of laptops on which the Tribunal Assistant can prepare typed up decisions on the spot. Computer software programmes should be installed that enable the operational side when empanelling Members, rationally and quickly to identify those Members who are nearest to the venues, who are free at the time needed, and to ensure panels are gender balanced.

Full-time chairs must be appointed in sufficient numbers to handle high quality training and appraisals as well as to form a leadership backbone of highly able and knowledgeable members. This last should start now as part of the lead up to new legislation. I argue that clerks should be appointed to support the hearings who will both take a full note of the evidence and type up the decision on a computer/laptop immediately after the decision is made and the Reasons settled.

### *Tribunal Independence and Convention Compliance*

The independence of the MHT is a vital component of the success of the MHT. MHRTs have, of course, always asserted independence in practice, but the reality of independence may be thought to be undermined by the low funding status the MHRT has 'enjoyed' within the Department of Health (DoH). Both the reality and appearance of full independence are vital for any judicial body's acceptance and authority. But no provision giving the Mental Health Tribunal independence of the DoH appears in the draft Bill.

It is arguably a Convention breach that a Tribunal which decides on the issues of compulsion of patients is run and funded by the very same body, DoH which runs and funds the National Health service, who are responsible for detaining most of the patients concerned. The case of *Smith v Secretary of State for Trade and Industry* (Times 15/10/99) shows that this question is no longer a theoretical one.

To resolve this problem, it has for some years now been agreed by the Lord Chancellor's Department, the Regional Chairs and DoH that at the first legislative opportunity, provision would be made for the MHRT to be made independent of the DoH, either by transferring the MHRT to the Lord Chancellors Department, or by making the MHRT an independent non-departmental, government body, similar to the Parole Board. While the Leggatt reforms may resolve the problem, it is not yet clear if, how far or when the Leggatt reform proposals will be implemented. In the meantime, it is essential that the vital strengthening of MHRT independence is not lost.

### *Medical Members*

I am anxious that we will be losing the Medical Member in its traditional form, and in the light of the recent case of *Dervis Said v MHRT* (CO/3084/2002) decided on 27th November 2002 by Burnton J, I do not now believe that change is necessary to safeguard the MHT from Convention challenge.

Even under the current Act, there are many cases where the basic medical evidence is not seriously disputed, or disputed at all. Instead the enquiry often centres on the meaning of the evidence as far as the tests in sections 72 and 73 MHA 83 are concerned. Although the participation of a Consultant is of enormous help to a Tribunal, such matters may be resolvable with the help of a 'clinical' member who is not a consultant. Under the draft Bill's regime there will also be such cases: some patients may not contest the 'gateway' section, or if they do, contest it on grounds that can be adjudged satisfactorily by non Consultant Members.

Given the shortage of senior Consultant Psychiatrists from whom existing Tribunal Medical Members are drawn, it seems inevitable that the use of such Consultants (and perhaps Consultant Psychologists) will have to be focussed on those cases for which there is a compelling reason for using one, for instance where there is a disputed diagnosis. In other cases, the Tribunal could use 'clinical' members who will be experienced and specially selected.

Interlocutory procedures and Rules will be needed to identify the types of case which justify the membership of a Consultant on the Tribunal panel.

The Tribunal administration would have to be funded much more generously than at present, because it would have to be more proactive not only in getting reports in early but also to identify

whether the case justified the use of a Consultant Psychiatrist on the panel. For this the administration would need to seek a high degree of advance disclosure about the areas of dispute from patient representatives. A full-time President could screen cases ahead of listing to allocate the cases correctly.

The default position if a patient were unable to give clear instructions on this to his/her solicitor would be not to use a Consultant, but if necessary, the Tribunal could direct a short adjournment for such a Consultant to be empanelled. The preliminary report should always be supplied by a Consultant Member.

More controversially some cases which are completely uncontested might be suitable to be dealt with on the papers, subject perhaps to the approval of the medical panel member's report and the patient's solicitor.

A further safeguard will be the possibility of an appeal to the MHAT.

### *Tribunal Rules.*

I see two omissions in schedule 4 (which sets out the provisions which will generate Rules):

- (i) Regional Chairs/the National President need a power to make Practice Directions to encourage 'best practice' and regulate such matters as single member sitting and paper hearings.
- (ii) Paragraph 1 (s) of schedule 4 enables rules to be made for decisions to be set aside essentially for clerical errors. This provision is unduly restrictive. The power to set aside decisions should be extended to cases where the Regional Chair identifies illegality in the procedure or unlawfulness in the Reasons. See my comments on s 67(1) of the MHA 83 below.

The Regional Chairs and Liaison Judge should be involved in the drafting of the Rules to ensure they are practical and workable.

### *The Care Plan and Convention Compliance*

No power is given to the MHT to deal with the situation where the clinical team fails to offer an acceptable Care Plan, particularly in those cases which cause the greatest problem now, where a restricted patient is ready to move on to lesser security or out of hospital to a 'non-residential' phase of his/her treatment.

If no teeth are given to the MHT, it is predictable that sooner or later the new legislation will be found wanting at Strasbourg. (The recent case of *R (on the application of IH) v Secretary of State for Home Department (1) Secretary of State for Health (2)* [2002] EWCA Civ 646 was an attempt to have the MHRT's powers declared inadequate in Convention terms on this point. See the discussion on *IH* by David Mylan in the July 2002 issue of this Journal (pp 208 - 218)).

One way forward would provide that where the clinical team and/or services, to which the patient is due to be transferred as a result of the MHT's decision, disagree with that decision and decline to execute it, a special review by the MHT or MHAT could be arranged at which the dissenting clinicians are represented. If then after hearing the arguments of these parties, the MHT/MHAT still upheld the decision, the dissenters would be required to execute it (as any Court order).

This reform would not only overcome the criticism that the Tribunal lacks the characteristics of a Court under the Convention, but also help to speed through the system cases which are currently subject to blockage, and so result in patients being wrongfully denied their liberty.

### **Compulsion in the Community**

Patients understandably fear that under the proposals in the draft Bill, they might be subjected to more, not less, compulsion. This may be true because compulsion in the community will be used in cases where patients now escape compulsion – and regrettably then not infrequently relapse.

But the opportunities for challenging treatment decisions that affect patients will be greater in the draft Bill than they are under the present legislation, and indeed these challenges can be predicted to constitute the greater part of the business of the new Mental Health Tribunal (MHT).

And of course the MHT will inherit the central principle of upholding a culture of respect for the patient and of the use of the least restriction on the patient compatible with the maintenance of the patient's health and safety and the public's protection.

### **DSPD and no crime committed**

A principal criticism of the draft Bill is that citizens could be sectioned when they have never committed any crime. This is a strange criticism as of course civil sectioning already applies in these circumstances. Public criticism is, I think, misplaced. This is because no person will be sectioned under this provision without serious evidence of the DSP disorder and of dangerousness, which will inevitably include proof of incidents which could have led to convictions, but have not done so perhaps only because the patient has for instance been diverted from the criminal justice system under Home Office circular no. 66/90 and its successor circulars.

However, I propose it would be prudent:

- (a) to reassure the public that one of the main objectives of this provision will be to catch paedophiles (and other violent offenders) who come to the end of a determinate sentence and have to be released when it is clear on the best available evidence that they have not engaged in treatment and remain very dangerous, and are very likely to re-offend, and that these people in effect have shown their dangerousness by their original crime, coupled with no evidence that they have reformed, and
- (b) to find a form of words that imposes clear tests of dangerousness in such circumstances. It may be necessary in some instances in all fairness to have detailed trials of the facts where no criminal conviction exists, perhaps with witnesses called to testify to the facts. Although Tribunals commonly do not call witnesses to investigate disputed facts, they always have the option to do so when necessary.

### **Racial Discrimination**

Critics say that the draft Bill will do nothing to eliminate the over-representation of ethnic minorities among detained patients. It is doubtful whether this mischief is curable simply through legislative provisions. An alternative view is that the problem is slowly being addressed through greater cultural awareness and understanding, but the overall pressure on ethnic minority people caused by the nature of UK Society will take years of cultural change to ease.

### **Exclusions**

The consultation on the exclusions to be written into the Bill rightly makes it clear that the exclusions still need to be clearly formulated.

The overwhelming number of patients who receive mental health services voluntarily consent to treatment. Of those who have to be sectioned, the majority pose little or no danger to others, but are themselves vulnerable. But the few who do pose a threat to others attract great public concern.

It is surely the legitimate business of Government to promote the health and safety of all citizens, whether mentally ill or not, to search for a balanced form of words in the draft Bill to achieve this aim, and to eliminate the defects of the present system, which has at times released dangerous people.

For instance, disagreements about treatability have arguably both unnecessarily undermined public safety, and denied some patients the care and treatment which they desperately needed, and could eventually have benefited from. Attempts to argue untreatability have generally been associated with a failure to understand the broad definition of medical treatment in s 145 of the 1983 Act, (substantially repeated in the draft Bill).

### **Law and Order? Crime Prevention and Joined-up Government**

Indeed the Government's proposals could logically have gone even further, and still be within the terms of Article 5 of the European Convention on Human Rights, for example by proposing the detention and specialised treatment of those long term alcoholics and drug addicts,

(a) who are severely and dangerously personality disordered, and

(b) who are habitually violent or commit serious offences as a result of drink or drugs.

Experience suggests that mental disorder (in a wide sense) is typically present among these groups and statistics show that they are a major source of crime.

### **Sharing Information on Patients**

Difficulties have been experienced in a small number of hospitals over access to patients' medical records to solicitors, when they are urgently needed in connection with Tribunal representation. Regional Chairs have had to direct hospitals to afford access. Confidentiality concerns are misplaced here.

In clause 170 of the draft Bill, it would be helpful to impose on hospital managers a duty to supply access speedily to patients' solicitors.

### **Duty to Examine v Right to an Assessment**

One of the criticisms of the Mental Health Act 1983 is that patients who ask for help are at times turned away for various reasons. The draft Bill (in clause 9) imposes on the 'appropriate Minister' a duty to arrange an examination if requested, but fails to provide any enforcement mechanism to ensure this duty is taken seriously by managers on the ground. It is therefore only enforceable by judicial review, which is not a readily available remedy for a potential patient!

The Bill could, it is suggested, give a patient a right to apply to the MHT if he/she is turned away in this way. Such a provision would make it more likely that managers focussed resources on the

delivery of this important service for patients. The hearing would have to be held within days to be of any use to the patient.

On a complaint that a request for an assessment was refused, the Tribunal could direct the examination (if it felt one was warranted). Without some teeth such a duty is likely to be weak.

### **Section 67(1) of the Mental Health Act 1983**

This section gives the Secretary of State a power to refer to the Tribunal the case of an unrestricted patient (and those subject to guardianship) 'if he thinks fit'. This is interpreted essentially as an administrative power, to ensure patients get a hearing when they might otherwise not have one. But there are occasions when a judicial review, and the expense and delay that judicial review causes, could be avoided, and speedier (and cheaper) justice delivered, if the Regional Chairs had a judicial version of this power, namely to set aside a clearly unlawful decision and to order a fresh hearing, as do for instance the District Chairs in The Appeals Service. Regrettably there is no provision for such a power in the draft Bill.

### **Safeguards**

I share the concerns of commentators who are nervous that the safeguards currently in place under the 1983 Act are to be abolished. The MHAC's role is I believe vital and should not be diluted in any way. However the abolition of the Nearest Relative's right to discharge is not so great a loss, as the Nominated Person (a person likely to be more acceptable to the patient than the Nearest Relative) will have a right to apply to the Tribunal for the patient's discharge under clauses 28 and 42 of the Draft Bill.

### **Conclusion**

I recognise that the draft Bill still needs strengthening and clarifying, and that the definition of mental disorder needs tightening, but my greatest concern is that the successful fulfilment of the Draft Bill's admirable objectives will depend on the generosity of the level of Government financial commitment. For example, the ready availability of both a genuine right to an assessment and help when requested depends upon further increases in resources, person power and training, fresh commitments for which must be made ahead of time, i.e. now.

## *Response by Robert Brown, Independent trainer of Approved Social Workers and Mental Health Act Commissioner, to the Draft Mental Health Bill*

### THE CHANGING ROLE OF THE APPROVED SOCIAL WORKER

Key elements of this article were originally included in two separate lectures at conferences hosted by the Institute of Mental Health Act Practitioners on 7th February 2000 and on 7th March 2001. The material has been revisited in the light of the publication of the Draft Mental Health Bill.<sup>1</sup> Although a new Mental Health Bill was omitted from the Queen's Speech on the 13th November 2002, the Government has stated its intention to introduce one as soon as time allows.

#### Summary

There has been concern in social work circles that mental health law reform will lead to a dilution of the role of the Approved Social Worker (ASW). This is against a background of major changes in the way social workers are employed in the mental health field. The article considers: key issues affecting ASWs in recent proposals, the history of the ASW, their key tasks under the current Mental Health Act, and changes in the way ASWs are being employed. There is then some discussion of the potential future for Approved Social Workers.

#### Mental health law reform proposals of consequence for Approved Social Workers

The Green Paper<sup>2</sup> was published in November 1999 and asked the following question:

- Should the applicant for admission be an ASW or could they be a mental health professional with specialist training or recent knowledge of the patient?

The White Paper published in December 2000 stated that 'the third person [i.e. in addition to two doctors] will be a social worker or another approved mental health professional with special expertise in the care of people with serious mental disorder, and where relevant learning disability, who will be responsible under the new legislation for co-ordinating the preliminary examination process'.<sup>3</sup>

The Explanatory Notes<sup>4</sup> published at the same time as the Draft Bill elaborates on Clause 2(9) of the Draft Bill (which defines 'an approved mental health professional' as a person who 'falls within a description specified by the appropriate Minister in regulations'). Note 11 says as follows:

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1 *Draft Mental Health Bill. Cm 5538-I. Department of Health 2002*

2 *Reform of the Mental Health Act 1983. Cm 4480. Department of Health 1999*

3 *Reforming the Mental Health Act – Part 1 The new legal framework. Department of Health and the Home Office 2000. At para. 3.32.*

4 *Draft Mental Health Bill. Cm 5538-II. Department of Health 2002*

“AMHPs [i.e. Approved mental health professionals] are likely to be social workers and members of other professions such as mental health nurses. There will be a requirement for those who intend to carry out the role of AMHP to undergo training and have a set level of understanding of mental health legislation and in assessing the non-medical aspects of treatment. Only then will the mental health professional be “approved” and able to carry out this role.”

The main concern in this article is with the central role that has developed for the ASW in the use of civil compulsion. Awareness of this role, and the way it has developed, is essential before reaching any judgment on the clear Government intention to move from ‘ASWs’ to ‘AMHPs’.

### **The History of the ASW**

The Approved Social Worker’s role in England and Wales grew from that of the Mental Welfare Officer (MWO) under the 1959 Mental Health Act. The MWO was often seen as a possible applicant when there was no relative available, as well as someone who could co-ordinate the process of admission. Over time it became the custom, rather than the exception, that the MWO would be the applicant. It is interesting to note that a similar process is now occurring in Northern Ireland where an increasing proportion of applications involves ASWs rather than relatives.

Reasons for the MWO being the applicant included:

- They developed a certain expertise (assessing social circumstances and their links with behaviour, mobilising resources and knowing the relevant personnel, ensuring any intervention was the least restrictive necessary in the circumstances, knowledge of the law and related procedures, and the ability to make a decision);
- It took the pressure off relatives if the MWO made the application; and
- After the Local Authority Social Services Act of 1970, the MWO could be seen clearly as independent from the medical profession as they worked for the new Social Services Departments rather than the local health authority.

There was a dilemma in 1974 when, apart from those based in Special Hospitals such as Broadmoor, hospital-based social workers became part of Social Services Departments. Such workers were allowed to become MWOs. This was based on the argument (put by Baroness Faithfull in the House of Lords) that their knowledge of patients and resources as well as their employment status outweighed any disadvantage that they might be seen as potentially collusive with the psychiatrist. A Secretary of State letter dealt with this concern by saying that where a hospital-based MWO feared that they would not be seen as independent, they could ask for the assessment to be made by another MWO.

Some concern was expressed in the 1970s about a loss of mental health expertise but the social worker remained as the usual applicant.

With the amendments to the Mental Health Act in 1982 there were tighter expectations of the new Approved Social Worker in terms of training, competence and specific duties (such as interviewing the patient in a suitable manner).

### Statutory basis for employing ASWs

Section 114 of the Mental Health Act 1983 states the following:

- “(1) A local social services authority shall appoint a sufficient number of approved social workers for the purpose of discharging the functions conferred on them by this Act.
- (2) No person shall be appointed by a local social services authority as an approved social worker unless he is approved by the authority as having appropriate competence in dealing with persons who are suffering from mental disorder.
- (3) In approving a person for appointment as an approved social worker a local social services authority shall have regard to such matters as the Secretary of State may direct.”

The relevant circular,<sup>5</sup> containing the Secretary of State's directions, gives the General Social Care Council control over training requirements. From 1995 all ASW training programmes have needed to assess specific competences. Prior to this, the responsibility for assessing the competence of ASWs was left exclusively with local authorities. They still retain a responsibility as seen in section 114 but the development of the new courses has probably led to more consistency across authorities in terms of standards. The circular states:

“14. Approved social workers should have a wider role than reacting to requests for admission to hospital, making the necessary arrangements and ensuring compliance with the law. They should have the specialist knowledge and skills to make appropriate decisions in respect of both clients and their relatives and to gain the confidence of colleagues in the health services with whom they are required to collaborate. They must be familiar with the day to day working of an integrated mental health service and be able to assess what other services may be required and know how to mobilise them. They should have access to, consultation with and supervision from qualified and experienced senior officers. Their role is to prevent the necessity for compulsory admission to hospital as well as to make application where they decide this is appropriate.”

### Approved social workers' tasks (with section references)

As is apparent from the list which follows, ASWs have a number of statutory duties set out within the 1983 Act. Note that those tasks which are marked with an asterisk can only be performed by an ASW.

- ss6&137 If an application is made, the ASW has the powers of a constable to convey the patient to hospital (see chapter 11 of the Code of Practice).
- s8 The ASW may be asked to carry out the functions of guardian by the Local Authority.
- \*s11(3) To take such steps as are practicable to inform the nearest relative that an application has, or is about to be, made, and inform them of their powers of discharge under section 23. This should include reference to s25 RMO blocking power regarding danger.
- \*s11(4) If it is an application for admission for treatment or for guardianship, to ensure that the nearest relative does not object to the application being made, unless this is not practicable or would involve unreasonable delay.

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<sup>5</sup> LAC(86)15

- \*s13(1) “It shall be the duty of an approved social worker to make an application for admission to hospital or a guardianship application in respect of a patient within the area of the local social services authority by which that officer is appointed in any case where he is satisfied that such an application ought to be made and is of the opinion, having regard to any wishes expressed by relatives of the patient or any other relevant circumstances, that it is necessary or proper for the application to be made by him.” In carrying out this task the ASW must interview the patient in a “suitable manner”; consider “all the circumstances of the case”, including: past history of the patient’s mental disorder; the patient’s present condition; the effect on this of any social, family and personal factors; the wishes of the patient; medical opinion. The ASW should consider: informal admission; day care; out-patient treatment; Community Psychiatric Nursing support; crisis intervention centres; primary health care support; social services provision; friends, relatives, voluntary agencies. The ASW must then decide whether “detention in a hospital is in all the circumstances of the case the most appropriate way of providing the care and medical treatment of which the patient stands in need” (s13(2)). Although it is important to stress that the ASW is acting as an officer of the local authority who are accountable for the ASW’s actions, it should be noted that the ASW also carries a personal responsibility in making this decision.
- s13(4) If required to do so by the nearest relative, the Social Services Department must direct an ASW to assess whether to make an application for detention.
- \*s13(4) If the ASW does not apply they must give reasons in writing to the nearest relative.
- s14 If the nearest relative applies for detention under section 2 or 3, a social worker must “interview the patient & produce a report on his social circumstances” for the hospital managers.
- \*s25B Where appropriate and having regard to the patient’s history, to provide a written recommendation in the prescribed form for supervised discharge.
- \*s29 In certain circumstances, to apply to the County Court for the displacement &/or appointment of a nearest relative for the patient.
- \*s115 To enter and inspect premises where there is reasonable cause to believe that a patient is not under proper care.
- \*s135(1) To apply for a warrant to search for and remove to a place of safety patients or persons living alone or in need of care.
- \*s136 To interview a person arrested by the police under s136.
- s48 National Assistance Act 1948 If a patient is admitted to hospital or Part III accommodation, then the local authority must ensure that any moveable property of the patient is protected.

In addition, the Code of Practice (para 11.13) states that the ASW “should leave an outline report at the hospital when the patient is admitted, giving reasons for the admission and any practical matters about the patient’s circumstances which the hospital should know.” Subsequent advice<sup>6</sup> states this should also include information about any children and possible arrangements for them to visit.

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6 LAC(99)32

There were initial problems in making the arrangements for training and assessment of ASWs and they were not appointed as such until 1984. It then took a number of years for the job to be seen as one that would normally be undertaken by mental health specialists. Also, with the collapse of CCETSW's<sup>7</sup> initial system of examination, the training courses were not formally required to assess trainee ASWs until 1993. Since that time I would suggest that there has been a better standard of work, increased knowledge of the legal issues and more consistency of approach. There are moves to standardise the arrangements for re-approval (which has to be at least every 5 years).

### **Why should these tasks be performed by ASWs?**

The key areas for the purposes of this short article are those concerning the making of applications for detention or guardianship, and the making of recommendations for after-care under supervision. Apart from practical questions (such as who else would actually want to be involved in these processes) we need to look at the reasons for ASWs, rather than other professionals or, as currently, nearest relatives, taking on these tasks. It is the co-existence of these factors that seems to me to be an important safeguard.

The following seem to me are all legitimate views and they were noted to a greater or lesser extent in the Report of the Expert Committee:<sup>8</sup>

- (1) ASWs are independent from the medical profession in terms of employment base, accountability and training. In general the personal accountability for decisions has allowed them to achieve a "creative tension" with medical colleagues (an expression that I believe William Bingley first coined when he was MIND's Legal Director).
- (2) ASWs have developed an expertise in co-ordinating the assessment, in the process of conveyance to hospital, and in dealing with the family and social implications of detention or guardianship.
- (3) In their basic ASW training and refresher training they have developed a culture of seeking the least restrictive alternative based on an awareness of liberty issues, social models of mental disorder and relevant resources.
- (4) ASWs undergo specific post-qualifying training which lasts a minimum of four months and includes a detailed study of the Mental Health Act and a formal assessment of their knowledge. This is invaluable in working to the Act, and I believe it benefits service users, carers and professionals involved in the process.
- (5) While being independent, they are, nevertheless, familiar with resources because they are usually directly involved with mental health services.
- (6) They are not directly involved with the continuing consequences of the deprivation of liberty, such as preventing people from leaving a ward or the administration of unwanted treatments. (The exceptions to this last rule are rare but significant in the current context. For example some ASWs have been involved in making an application for guardianship and have then carried out the functions of guardian. Equally some have made a recommendation for supervised aftercare and then taken on the role of supervisor.)

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7 *The Central Council for the Training and Education of Social Workers.*

8 *Report of the Expert Committee; Review of the Mental Health Act 1983, Department of Health 1999.*

### **The impact of joint working with Health on the independence of ASWs**

There have been recent changes in the way that ASWs are being employed in England and Wales. I am currently involved with both basic and refresher training for ASWs in Somerset and I am also the External Assessor for the ASW programme in Northern Ireland. Northern Ireland ASWs are working to different legislation but there are some important parallels with the English and Welsh systems. Like the Trust system in Northern Ireland, the Somerset Partnership is a single health and social service agency and, although the ASWs are still technically employed by Somerset County Council, they are well integrated with health colleagues in day to day work. Similar developments have taken place in Wiltshire and elsewhere, and this is certainly the direction in which movement is expected across England and Wales.

While such systems have the benefit of involving ASWs in mental health services, they do raise important questions.

- How independent can the ASW be (or be seen to be)?
- How will the ASW link with other relevant services such as child care, disability (including learning disability) and old age?

The ability of the ASW to make their decisions in a way which preserves the ‘creative tension’ with doctors may depend less on their employers and more on maintaining a professional line of accountability and support for their role as in Northern Ireland. They may also be seen to have a positive role in maintaining links with social workers and social care colleagues in child care, disability services etc.

### **ASW to AMHP**

Whatever happens to the Draft Bill, it looks as though professionals will still be able to detain an individual without first going to a court or tribunal. In these circumstances I am left with the view that there should be clear limitations on who could be the equivalent of the current applicant, and a clear expectation of their role.

There are a number of issues raised by the changes envisaged in the Draft Bill. For example, for independence reasons we may move to a position where an applicant comes from a team other than that which will be providing the compulsory 28 day assessment. The loss here would be, that it will be even more unlikely that the patient will know the applicant, especially for community based assessments; on the other hand the need for independence may outweigh this concern. I hope it does not lead to a roving crisis team approach. If most assessments are still undertaken in hospital it could well be that the applicant will know the patient, depending on how mental health teams are organised.

### **Effect of various professions taking on the AMHP role.**

If other professionals are to be applicants, then knowledge of the patient would not seem to be enough. The strength of the current position is the balancing perspective and potential “creative tension” which is inherent in the ASW role. This is based on the six views identified above. It may well be that other professionals could achieve these as well as, or better than, current ASWs, and if this is the case I can see little objection to change. Indeed many of the original Mental Welfare Officers had nursing backgrounds and it may be that it is the essence of the role itself that leads

to the creative tension. But it is a big 'if' concerning the introduction of other professionals, and I am not sure that many service users would see nurses as providing an appropriate balance to the medical view of doctors. On balance I can see no major advantage in having anyone other than the ASW as applicant and several potential disadvantages if this were to be changed.



