

## **Papers in relation to the draft Mental Health Bill to be considered at the BASW MHSIG Executive Committee meeting on August 22nd.**

Below are the three documents, which, in addition to members' responses which are being collated by John Myers, will form the basis for discussion about the draft Bill on the 22nd. All members of MHSIG are welcome to attend. The documents are:

- the submission to the Parliamentary Joint Human Rights Committee, which in view of their deadline has already been sent and is now a public document
- two further documents from Roger Hargreaves which are intended as a basis for an eventual response from MHSIG. The general lines of that response will need to be agreed on the 22nd and the final document must then be submitted to the DoH by September 16th.

The government appears determined to railroad this Bill through against almost universal opposition, and consultation over the holiday period is no doubt a deliberate tactic. In order to frustrate this tactic we need to ensure that the consciousness of social workers and social work organisations to the major issues is raised as quickly as possible, by circulating information as widely and as quickly as we can. Whilst MHSIG has yet to formally determine its stance, therefore, it would be very helpful **if you could copy these documents on as quickly as possible to anyone who is likely to be interested and supportive.** In particular, we need to target SSD Mental Health Managers and other people who may be involved in drafting official responses, many of whom will not have time to read and digest the Bill properly before the September deadline.

### **BRITISH ASSOCIATION OF SOCIAL WORKERS MENTAL HEALTH SPECIAL INTEREST GROUP**

#### **SUBMISSION TO THE JOINT COMMITTEE ON HUMAN RIGHTS IN RESPECT OF THE DRAFT MENTAL HEALTH BILL - JULY 2002**

*MHSIG is a national forum representing social work in mental health, which is constituted as a sub-committee of BASW. Its membership is, however, open to non-BASW members and includes non-affiliated Approved Social Workers, consultants, social researchers, academics and others who share the following aims:*

- *to promote a partnership with user and carer groups in order to achieve better services in mental health*
- *to provide support for practitioners in the field*
- *to offer an opportunity to exchange information and ideas in the field of mental health, to provide a forum for discussion and identification of main areas of concern*
- *to provide informed comment on policy and practice issues for interested parties and to influence decision making*
- *to develop anti-discriminatory policies and practice in mental health*

#### **Our concerns**

1. This submission restates the specific concerns about the human rights implications of the White Paper "Reforming the Mental Health Act" which were set out in MHSIG's paper "Reforming the Mental Health Act - Alternative Proposals" which we submitted to the Department of Health in December 2001 and which is available, with a summary, on our website at [www.basw.co.uk/mhsig](http://www.basw.co.uk/mhsig). Scrutiny of the draft Bill and related documents confirms that the DoH has not addressed any of the human rights concerns expressed in that paper.
2. These concerns centre around the **proposed procedures for examination and compulsory assessment** which are now contained in Chapter 2 of the draft Bill; these are the entry point for the application of the civil powers. Under the present Act, these initial procedures require an application to be made by an Approved Social Worker (ASW) which is supported by two medical recommendations; this then gives the hospital the authority to detain and to treat the patient for up to 28 days before a fresh application is required. The patient or his or her nearest relative may appeal immediately or at any time during the first 14 days to the Mental Health Review Tribunal, which will then hear the case within the next 7 days.
3. The draft Bill requires that after 28 days, any further detention must be authorised by a Tribunal, but up to this point it retains the present framework, **with one very important exception.** Under the present Act the ASW, in addition to being an experienced qualified social worker with an additional specialist qualification, must be an "officer of the local authority" (Section 145(1)). This ensures that the ASW is clearly independent of the detaining hospital or Trust and of the qualified psychiatrist who must make the primary medical recommendation (the second recommendation usually comes from a G.P.)

In effect, the ASW takes the place of a court in the initial process, in that he or she is an independent non-medical authority who makes the final decision on a proposal for compulsory treatment made by the psychiatrist and the hospital. In the draft Bill, however, the ASW is replaced by an "Approved Mental Health Professional" (AMHP.)

4. The government's intentions with regard to the AMHP are clearly stated in the Consultation Document (page 22.) AMHPs "*may be social workers (and are likely to be in the early years of the new legislation...)* The aim, however, is to enable other mental health professionals such as mental health nurses, psychologists and occupational therapists to take on this role as well."

5. In practice this means the mental health nurses, since this is by far the largest professional group in the mental health services and the only one which is remotely likely to express a willingness to assume this role. Nurses are, however, not only NHS employees with a clear line of accountability to their employing Trust (i.e the detaining authority), but they are also professionally bound to defer to doctors on clinical matters. The government therefore envisages the eventual replacement of the ASW with an official who will have very little if any scope for the exercise of independent judgement vis-a-vis the psychiatrist and the detaining authority.

6. It is also questionable whether social workers will, as the government believes, take on the AMHP role in any numbers in the early years of the new Act. The present-day ASWs regard their independence as *the* crucial element of the role, and are concerned that it is already being compromised by secondment of ASWs to NHS-managed joint services. However, with the transfer of local authority mental health services to Care Trusts, which is likely to be virtually complete by the time the new Act is implemented, they will themselves become NHS employees and will therefore become subject to the same managerial accountability as the nurses. Recruitment to ASW posts is already falling, as social workers perceive that they are shortly to be "written out" of the legislation, and this process will accelerate as the implementation date approaches, as social workers will see little point in seeking approval (or renewal of approval, which requires refresher training) for a role which is going to disappear.

7. It is therefore inevitable that the AMHPs, whether they be social workers, nurses or from any other health profession, will not be demonstrably independent either of the detaining authority or of the psychiatrist, who is very much the most powerful player in the initial detention process.

8. The government's only apparent concession to independence for the AMHP is contained in Clause 9(5)(b) of the Bill, which says that the AMHP "*must not fall within a description of persons specified by the appropriate Minister in the regulations as being subject to a potential conflict of interest as regards acting in relation to a person of the patient's description.*" The meaning of this is unclear, but we suspect that it refers to nothing more than the provisions in the present Act which prevent doctors from acting together with their spouse, or professional or business partner, or where they have a financial interest in the patient. These provisions were not extended to ASWs since, as local government officers, for them to act in this way would in any case be a "corrupt practice" under local government law.

### **The implications of the draft Bill**

9. It is likely, therefore, were this Bill to pass into law, that within a few years at most, the majority of decisions to detain a patient for up to 28 days would be made by a consultant psychiatrist and a nurse who would both be employed by, and accountable to the detaining body, and who in the case of the nurse would be professionally bound to defer to the psychiatrist on clinical matters.

10. The government may argue that nurses are becoming less subservient to doctors, and this is indeed so and very welcome, but we are many years away from the point at which a nurse, other than one of great seniority, can realistically veto a consultant's decision to admit or to impose treatment on a patient, other than by refusing an unlawful instruction. If this were to be seriously proposed it would cause an upheaval throughout the entire NHS and would not necessarily be welcomed by the nurses themselves, since it would open them up to the legal liability which currently attaches to doctors (and to ASWs, who are being sued with increasing frequency.)

11. Alternatively, the government may argue that the second medical examiner already provides an independent element which makes the independent ASW redundant. However, as we argue in more detail in our "Alternative Proposals," this safeguard is largely illusory. The "second doctor" is usually a G.P, without specialist psychiatric training or knowledge of mental health law, and due to the changes in general practice is much less likely than formerly to know the patient personally or to have any continuing responsibility for his or her care. In addition, of course, a non-specialist doctor is in much the same position as the nurse, in that professional protocol limits the extent to which he or she can properly disagree with the opinion of a consultant specialist, especially when he or she is not the patient's personal G.P. As a consequence, whilst ASWs detain only 65% of the patients referred to them for possible admission, a refusal by a second doctor to agree to an admission requested by a consultant is a very rare event.

### **The government's view**

12. The response from the DoH to our concerns about the loss of the independent ASW is that ECHR compatibility will be ensured by the enhanced role of the Tribunal. However, the bald statement in the consultation document (page 6) that "*in*

*particular, the Bill will require all decisions to apply compulsion to mentally disordered people to be taken by an independent body" is **blatantly untrue**. A Tribunal hearing will not be *automatic* until 28 days, by which time, as the consultation document itself acknowledges (page 8) "*as now, most patients will be discharged from compulsory treatment.*"*

13. Prior to 28 days, patients will, as at present, have the right to apply for an "expedited hearing." The Bill does not lay down the timescales - these are left to the Lord Chancellor - but it seems unlikely on logistical grounds that there there will be much if any improvement on the present 7-day gap between application and hearing, so this is likely to be the minimum period during which someone will be detained (and treated) without recourse to an independent judicial body. This is, of course, a very much longer period than is allowed under the criminal law.

14. However, under the present Act the vast majority of patients do not in fact apply for a hearing. They are often distressed and confused, may well be heavily medicated on admission, and are often fearful of challenging the authority of the doctors and nurses upon whom they are totally dependent. In addition, of course, unlike detainees under the Police and Criminal Evidence Act, they are not accompanied by a solicitor when they are interviewed by the psychiatrist. Research has, not surprisingly, demonstrated that the likelihood of appeal is related much more to the patient's level of education than to the strength of their case.

15. The government has, to its credit, conceded that vulnerable patients need more support, and has included in the Bill (Clause 159) a statutory advocacy scheme. However, it remains to be seen how effective this will be, and we and others have questions, which the Bill does not answer, about the training of these advocates and their independence of the detaining Trust which will be acting as their host. Experience of comparable schemes already in existence suggests that whilst it will be of value for patients who are detained long-term, it will have a marginal effect on the number of applications for "expedited hearings."

16. The government may argue that, even if the patient is unable to apply for an expedited hearing, their "nominated person" (replacing the nearest relative in the present act) will be able to do so on their behalf. However, although we welcome the draft Bill's provisions on "nominated persons," which closely follow our own proposals, we would expect that in most cases the nominated person will be the person who would have been the nearest relative under the present Act, and there is no evidence that nearest relatives currently make a significant number of applications; in fact, in a great many cases the nearest relative is the person who requested the admission to hospital in the first place.

17. It is reasonable to expect, therefore, were the present Bill to become law, that most patients, having been detained initially by a process which contained no genuinely and demonstrably independent element, would not then have their case reviewed at all by an independent body, since they would not appeal and would be discharged before the end of the 28-day period. Even if they did appeal immediately, they would be subject to detention and to compulsory medical treatment for at least 7 days. In fact, if present custom-and-practice, well-documented by the Mental Health Review Tribunal, is continued, a high proportion of patients will be discharged just a day or so before the automatic Tribunal hearing, ie at 26 or 27 days.

### **Our view on ECHR compatibility**

18. Our view, as stated clearly to the DoH last December, is that **the provisions in the Bill for examination and compulsory assessment are likely in the course of time to be deemed to be incompatible with Articles 5(4) and 6 of the ECHR**, on the grounds, firstly, that the vast majority of patients will not have their detention reviewed by a court or similar judicial body, and secondly that even for those who do, the remedy will not be sufficiently "speedy." We also pointed out that the ECHR is 50 years old, that it was largely drafted by English lawyers at a time when the Lunacy Act was still in force in this country (and it borrows the language of that Act) and that it does not reflect the development since that time of awareness of the rights of the mentally-disordered and is therefore likely to be modified by caselaw well within the lifetime of the new Act.

19. Current thinking is much better expressed in the Council of Europe White Paper "The Protection of Human Rights and Dignity of People Suffering From Mental Disorder" published in 2000, and the draft Bill would certainly not meet the standard set out in that document, which requires that the person or body making the decision to detain should be clearly independent of the person or body proposing the detention. The present Act does, however, conform to that standard, provided, that is, that ASWs seconded to joint services are still able to exercise demonstrable independence.

20. For the sake of brevity we will not describe in detail the alternative approach which we set out in December, and which essentially involves a redefinition and strengthening of the ASW role with a greater emphasis on its quasi-judicial elements ( and which opens it up to other professions provided they can meet the test of demonstrable independence.) If the ECHR incompatibility of this part of the draft Bill is accepted, there may be more than one acceptable way of overcoming the problem. However, we think it essential that **any process for initial assessment and treatment should conform to the principle that safeguards against unlawful or oppressive action should be comparable to those contained in other legal processes which result in a restriction or deprivation of liberty**. In practice, this means that the yardstick should not be just the ECHR, but also the criminal law and the rights and safeguards afforded to those detained by the police.

Papers by Roger Hargreaves:  
10/08/02

## **The draft Mental Health Bill - an initial overview.**

There are some good things in this Bill. In particular:

- the basic framework is sound
- they have accepted MHSIG's proposals on the "nominated person."
- as MHSIG recommended, the courts will be required to have evidence from an approved mental health professional (AMHP) before making a treatment order, and they will also have access to the "expert panel"

The statutory advocacy scheme is also to be welcomed. However - (Clause 159 (5)) - these schemes need only be independent of any person responsible for the patient's treatment "so far as practicable." If they are not *completely* and *demonstrably* independent, however, their value is questionable.

In general, however, this Bill makes very few compromises with the views of carers' and users' pressure groups and the professional bodies. With the limited exceptions above, MHSIG's proposals have been completely disregarded, although we are clearly not alone in that respect.

It is, of course, only a draft, and there are the usual errors and inconsistencies which you expect in a draft. We should not carp too much about these, because they can be corrected later, and it is better that we should see the document at this stage than when a Parliamentary slot has already been allocated. However, it does contain some very strange provisions which do lead me to question the practical understanding of the people who drafted it. For instance (Clause 11) if the first examiner to arrive on the scene (let us say the GP) does not think that the patient meets the legal criteria, then the other two (i.e the consultant and the AMHP) can't examine the patient. The logic of this escapes me, quite apart from the legal implications for the consultant's and the AMHP's duty of care.

The Bill also retains the second doctor without making any provision to ensure availability, other than removing the present requirement that one of the doctors, where practicable, should have previous acquaintance with the patient. This would widen the field of available doctors, but would remove the main "added value" of the second doctor - that he or she should know the patient if the psychiatrist does not. The RCGP has indicated that it supports the retention of the second doctor, rather than MHSIG's alternative proposal; if the BMA takes the same view, I think it is then incumbent on the DoH and the medical bodies to indicate how they will ensure ready availability.

It is also clear, ( Consultation Document page 22) that contrary to the assurances we have been given, the replacement of the ASW by the AMHP is not just a precaution in case ASW numbers fall too low, but is a deliberate policy to replace ASWs with nurses over a period of time. (Reference to psychologists and O.Ts taking on the role is just a red herring - their numbers are very small, and I can't imagine psychologists ringing around trying to find a second doctor on a wet Friday night.)

This raises the question as to whether the AMHP role, as set out in the Bill, is one which ASWs would want to assume anyway. It is clear that no real thought has been given to it, and that the authors of the Bill have, contrary to the explicit warnings in our evidence, simply inserted existing ASW roles and functions into the Bill whenever they seem convenient, without considering whether they add up to a coherent and practicable whole. As a result, most of the existing problems will be perpetuated, and some additional ones added.

The clearest indication of this lack of thought is that the authors of the Bill do not specify whether the AMHP, in relation to a particular patient or a particular episode of care, is a single named individual or whether the role can be passed from one AMHP to another ( and if so, who is responsible for doing this). In the present Act, the ASW's personal duty is limited to carrying out an assessment and admitting the patient thereafter - i.e a single discrete episode, which ends when the papers are handed over at the hospital. The draft Bill, however, prescribes certain duties for "the AMHP" which extend over time, with a strong implication that each patient subject to compulsion ( and also incapable informal patients under Part 5) will have their own personal AMHP who will remain in that role throughout the episode of care.

For instance, in Clause 15 (2), "the AMHP" must issue notifications if a patient admitted under the emergency provisions is then detained beyond 72 hours. Which AMHP ? The emergency duty team AMHP who admitted them in the early hours of Saturday morning, and who is now tucked up in bed ? You cannot (as in this case) lay duties on an individual official, as opposed to a corporate body, without first removing all ambiguity as to who that individual might be, and secondly providing a mechanism for transferring the role to another individual.

Significantly, the Bill makes precisely this provision in the case of clinical supervisors - Trusts are given a duty to appoint them, and the power to transfer that role to someone else. What has happened in the case of AMHPs is that the drafters have

taken the local authority out of the equation, but have not thought to put anything in its stead. There is no provision whatever for the appointment, training, deployment, or management of AMHPs or for avoiding conflicts of interest other than what might (or might not) be prescribed in regulations, and their legal status is even more ambiguous and exposed than that of the ASW, not least because they have a scattering of duties, some of which are essentially administrative (for instance, the requirement in Schedule 5 to notify the clinical supervisor when a court order is made) and will be personally liable at law for all of them, whereas the liability of the ASW at present is limited to assessment-and-admission and everything else is done "on behalf of the Director of Social Services."

There is also one new power, which may be a sensible provision in itself, but which will drastically increase the AMHP's legal exposure relative to that of the ASW. Under Clause 143, "on information from an AMHP" a police officer will be able to remove a person from his own home to a place of safety for up to 6 hours; an AMHP will have to accompany the police officer, although not, it would appear, necessarily the AMHP who "laid the information" which can be done by phone.

This power is the nearest equivalent to Section 20 of the Lunacy Act, under which the ASW's predecessor could admit to hospital for a brief period on his own authority. This was also intended to be a dire-emergency provision, but in practice was so convenient that it accounted for the majority of admissions prior to 1959, and I suspect that the same might happen again in some inner-city areas. The important point is that the police officer would be acting almost entirely on the AMHP's authority, and the latter would have to bear the brunt of any legal challenges, which are likely to be frequent.

In other respects, however, the AMHP is a significantly weaker role, and not just because (it appears) AMHPs will be Trust employees. Even though it appears that an AMHP will need to be appointed to each patient, primarily to deal with changes to the nominated person, the AMHP will not be consulted on applications to the Tribunal (although the nominated person and/or carer must be.) In the same vein, the AMHP need not be consulted by the clinical supervisor about a decision to "call in" a non-resident patient to hospital (although the AMHP will presumably be expected to make the arrangements for admission.)

This leads on to one of the most objectionable aspects of the draft Bill, in that it completely ignores the multi-disciplinary principle and the Care Programme Approach. Beyond the initial examination, all power is given to the psychiatrist, with no requirement to consult about anything with any member of the multi-disciplinary team, thus taking us back to the situation which existed prior to 1983. It is especially objectionable that care co-ordinators and community supervisors have no say in whether or not a patient should be supervised in the community or returned to hospital, or in the conditions attached to such supervision, even though they are the people who in practice have to implement these powers. This means that community supervisors could find themselves in situations of serious personal or professional risk without the ability to limit that risk.

In addition, the psychiatrist alone is responsible for the statutory care plan. This is presumably a different document to the CPA care plan drawn up by the care co-ordinator, but there is no provision for that document to be presented to the Tribunal nor, indeed, for the Tribunal to hear any opinions other than that of the clinical supervisor. The Bill effectively creates a parallel care planning process for compulsory patients which does not operate on a multi-disciplinary basis.

Moving on to the issues which are preoccupying most of the other bodies, I think it is clear that the "entry gate" to compulsion ( Clause 6) is now very wide indeed, and does remove the ambiguity in the White Paper about the admissibility of people with untreatable personality disorders. Medical treatment has to "be available," but as this includes nursing care it would be difficult to argue a legal case against the detention of someone who merely needed to be contained for life in a civilised environment, unless (which is not impossible) the courts were to rule on human rights grounds that such a broad construction of "treatment" was not sustainable.

In addition Clause 6 (4) (b) (ii) "that treatment cannot be provided to him unless he is subject to the provisions of this Act" does not apply to patients falling within 6 (4) (a) "substantial risk of serious harm." This means that someone in this category *must* be detained even though he or she is (and always has been) perfectly amenable to treatment. We might sometimes want to do this under the present Act, on the basis that "informal admission is inappropriate in the circumstances," but there is an element of discretion; Clause 11(3), however, does not appear to allow the three examiners to exercise discretion *not* to use compulsory powers where all the Clause 6 conditions are satisfied, so where the patient poses a substantial risk of serious harm, they must be detained even if they have turned up at the door begging for help.

In addition, however, Clause 121 states that informal treatment cannot be given to an existing incapable patient who is "at substantial risk of committing suicide or causing serious harm to other persons." This could substantially increase the number of people detained; for instance, many people with severe learning disabilities and challenging behaviours would at times fall into this category, but we would not normally section them unless they were trying to leave or needed prolonged physical restraint - if they are willing, or not unwilling, to take tranquillising medication, then so well and good, and the draft Bill does for the first time provide safeguards against the inappropriate use of such medication on incapable informal patients.

The provision relating to "substantial risk of committing suicide" is in any case illogical, since suicide (as opposed to unintentional fatal self-harm) is a deliberate act which will tend not to co-exist with incapacity in relation to treatment

decisions, hence the coroner's rider "whilst the balance of his mind was disturbed" which indicates lack of capacity to form a deliberate intent or to appreciate the dangerousness of actions. In addition, this provision cuts right across the conditions in Section 6.

Moving on to Community Treatment Orders, I have to say, as someone who is broadly sympathetic to the government's intentions, that all the furore in the press is fully justified. They have made not one concession to their critics and have not even attempted to camouflage their intentions, as was arguably the case in the White Paper. If a patient in the community is thought to be defaulting on medication, they will be forcibly brought to the clinic, forcibly injected, and then taken home. (Clauses 53 and 117) The transporting will be done by an "authorised person", but the expectation will surely be that this person will be an AMHP, whether or not he or she approves of what is being done.

**In summary**, however much the government might try to emphasise the positive safeguards for patients, this Bill is exactly what its many detractors are saying - it emphasises public safety at the expense of patients' rights, and it seriously limits the scope for professional discretion, at least as regards *not* using compulsory powers when they are available. It is inevitable, contrary to the government's stated intentions, that these provisions will lead to greater use of compulsory powers.

I can well understand why they appear to wish to write social workers out of the legal processes as soon as possible - insofar as there is scope for professional discretion in the application of these powers, I would expect social workers to push that discretion to the limits, and the government might reasonably conclude that nurses, under the tight managerial control of the Trusts, would be much more likely to operate the Act as they intend, whatever their personal and professional misgivings.

In particular, the Bill is regressive in that it puts virtually all power back in the hands of psychiatrists to the exclusion of the other professions, and thereby cuts right across the multi-disciplinary principle and the requirements of the Care Programme Approach. It opens up the prospect that, if the other professions do not fall into line, there could be two care planning processes operating in conflict with one another.

This raises the question as to what we should do now. The nurses and the psychiatrists will ultimately have to come into line, since they have few other employment options outside the mental health services, but social workers have no need to serve under conditions which they find intolerable. As it stands, I think that the AMHP role is totally unacceptable and we should be advocating a boycott of it, ditto the role of community supervisor. BASW, as a provider of professional insurance, is in a good position to say that the legal and professional risks are unreasonable.

This will place the government in a difficult position. Its strategy is based on the assumption that most existing ASWs will just passively "roll over" into the new Act and can then be gradually replaced. If they do not, it is faced with a massive logistical problem, which will not just happen on inception day, because before that time there will be increasing shortages of ASWs as existing staff retire or reach the end of their approvals and are not replaced. We may, therefore, provided we can get the support of the broad mass of ASWs, be in a better position to force concessions from the government than the other bodies, whose objections have clearly already been discounted.

10/08/02

### **Further thoughts on the draft Mental Health Bill.**

I have been looking in more detail at the entry criteria to assessment in the draft Bill relative to those in the present Act, and in particular at the extent to which the professionals involved have the freedom to exercise discretion. This reinforces my conclusion that the Bill is completely unacceptable in its present form, and that social workers should have nothing to do with it if it is not drastically improved.

In the present Act, starting with the medical recommendations:

"an admission for assessment *may* be made...on the grounds that

he is suffering from a mental disorder

*of a nature or degree* which warrants the detention of the patient in hospital...

and he *ought* to be so detained

(i) in the interests of his own health

(ii) in the interests of his own safety

(iii) with a view to the protection of other persons

( These criteria are listed separately as they now appear on the pink form, but not in the Act.)

"Mental disorder", even with the exclusions in Section 1(3), is extremely broad but is then heavily qualified by the next phrase, which allows the doctors the discretion to exclude disorders of a particular *nature* (e.g personality disorders) and to set a threshold of severity, which is essentially the threshold at which it would be acceptable to use force in order to detain and treat. Even if the patient meets those criteria the doctors are given further discretion in that they can then decide that the patient nevertheless *ought not* to be detained, (for instance if he will accept informal admission, or for whatever other reasons they think relevant). This discretion is further represented on the pink form by the phrase "informal admission is not appropriate in the circumstances of this case."

Then the ASW comes into the picture. Under Section 13:

"it shall be the duty of an ASW to make an application 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

before making an application....an ASW shall....*satisfy himself* that detention is *in all the circumstances of the case* the most *appropriate* way of providing the care and treatment...."

This gives the ASW very considerable discretion over and above that already available to the doctors, although the second phrase above ought perhaps to be discounted since it was inserted in 1982 for a specific reason and should strictly speaking finish "by him rather than by the nearest relative." The critical phrase is the third one. It requires the ASW to "satisfy himself" i.e to form a personal opinion rather than to act solely on the medical recommendations (Buxton v Jayne, 1960); it requires him to take into account every relevant factor, and gives him the freedom to decide what these should be; and it allows him to decide whether or not detention is "appropriate."

Although the requirement to take social and environmental factors into account isn't spelt out in the Act, it doesn't need to be, because the ASW is by definition a social worker and has a duty to consider "all the circumstances." On this basis, he can properly decline to make an application even where he has two medical recommendations, since his remit goes wider than the purely medical factors considered by the doctors.

Putting both the medical and the ASW criteria together, there is very considerable scope for the exercise of professional discretion, and for medical factors to be balanced against non-medical ones, including the social circumstances and the views and wishes of relatives and carers. If the professionals act "in good faith and with reasonable care" it would be very difficult to challenge a decision either way, because the law clearly gives them a great deal of freedom to exercise professional judgement, and I am not aware of any case where the actions of either a doctor or an ASW have been found to be unlawful other than on technical or procedural grounds.

Contrast this, then, with the draft Bill.

The "relevant conditions" are set out in Clause 6:

First - "that the patient is suffering from mental disorder." This is as in the present Act i.e absolutely everything you can find in ICD-10, and of any level of severity. ( The government is consulting on whether there should be any exclusions.)

Second - "that that mental disorder is of such a nature or degree as to warrant the provision of medical treatment to him."

This isn't quite as all-encompassing as it seems, since it is qualified by the definition of "medical treatment" in Clause 2(5) which is "treatment...provided under the supervision of an approved clinician." "Approved clinician" will be defined in regulations but will presumably be limited to consultant psychiatrists or psychologists, so the second condition could reasonably be interpreted as "...of such a nature or degree as to warrant treatment by a secondary mental health service."

This is, of course, something of a movable feast depending on where you live, but it at least excludes minor, time-limited conditions which can easily be treated in primary care. However, it would not exclude the more serious and persistent non-psychotic conditions, and in particular the people with multiple personality/substance misuse/antisocial behaviour problems whom GPs can't manage, unless it could be argued that the staff in secondary services who deal with these people are not doing so "under the supervision of an approved clinician." The staff may think this, however, but it is unlikely that a court would agree with them; under NHS law, the consultant is still responsible for everything, and this will include the work of social workers when they are transferred to Trusts.

The third condition has two alternatives, which need to be considered separately. First of all:

(a) "in the case of a patient who is at substantial risk of causing serious harm to other persons, that it is necessary for the protection of those persons that medical treatment is provided to him."

This ( and the other alternative) is then qualified by the fourth condition:

"that appropriate medical treatment is available in the patient's case."

It needs to be borne in mind that "medical treatment" here has the same meaning as in the present Act, i.e it includes "nursing" and "care" and therefore need not involve any active medical intervention. "Appropriate treatment" is therefore provided if a dangerous person is simply locked up under nursing care.

A great many people in the personality/substance misuse/antisocial group are "at substantial risk of causing serious harm to other persons" and in a great many cases this requires no subjective judgement but is simply an objective conclusion from their criminal record. Provided, however, that an "appropriate" bed is available they meet all four conditions. This is again largely a matter of fact; if a bed is unoccupied it is available, unless there is some objective reason to the contrary e.g age-group, wrong sex, need for higher security. The fact that the consultant/nursing staff/management don't wish to admit that particular patient is irrelevant, because the treatment is still "available."

The only opening which the three examiners have for exercising any discretion at all is the word "necessary." However, this is an extremely narrow opening. If the person is agreed to be at substantial risk of causing serious harm, then it is patently obvious that locking him up will protect at least those persons who are not sharing the ward with him. The only situation in which it would not be "necessary" would be if there were a more appropriate solution available, e.g imprisonment.

The other alternative is:

"(b) (i) it is necessary for the health or safety of the patient or the protection of other persons that medical treatment be provided to him, and

(ii) that treatment cannot be provided to him unless he is subject to the provisions of this Act."

The first leg sounds familiar but isn't, since the present Act says, in effect, that it is necessary for his health or safety etc for him to be *detained*, which is a very much higher threshold than simply "providing medical treatment." The second leg does at least allow someone who meets the first leg to receive treatment informally (or we would be right back to the Lunacy Act) but it doesn't *guarantee* informal treatment to a consenting patient, since the examiners can in this one instance exercise some judgement, as to whether treatment can or cannot be provided informally - in that respect it replaces the present phrase "informal admission is inappropriate in the circumstances."

Putting it all together, however, what this alternative means in practice is that, at the minimum, anyone who:

- has a mental disorder sufficient to bring him within the entry criteria for the secondary mental health service (or at least that part of it under the control of the consultant)
- needs treatment in the interests of his health
- isn't willing to accept appropriate treatment which is available

meets "all of the relevant conditions"( Clause 11 (3)).

So what happens then?

**The patient is liable to assessment**, either as a resident or a non-resident patient. If the examiners find all of the conditions met, **they have no discretion**, and the AMHP must register him. All the subjective elements of the present Act, which even when the minimum conditions have been met, allow the doctors to conclude that the patient nevertheless ought not to be detained, or the ASW to conclude that this is not the most appropriate way to provide care and treatment, have been eliminated. The examiners do not even have the right to take the patient's capacity into account, or their religious or cultural beliefs, or any negative social consequences of their being subject to compulsion, and the elaborate consultation with the carer and nominated person is a complete sham, other than as a means of obtaining information about risk, since any wishes expressed by them can be of no effect.

Whilst the draft Bill does not actually place on the examiners a *duty* to act, as the ASW has a duty under Section 13, it doesn't need to do so since the examination will be ordered by the provider Trust and at least two of the examiners will be Trust employees who can be directed to do it. If they then decline to make a determination in the face of objective evidence that the conditions are met, they will not only be very vulnerable to legal action but will also be liable to disciplinary action. At present, the ASW is safe from disciplinary action unless he makes a decision which is clearly perverse, since the law gives him personal discretion and his managers cannot substitute their own discretion. It would be a mistake, therefore, to

assume that doctors and AMHPs could simply subvert the government's intentions by declining to make determinations where, in their judgement, it is unreasonable to do so.

In addition, **the distinctive role and duty of the ASW has completely disappeared.** On the face of it, we might be glad that there is now complete parity between the three examiners, but in fact this is far from the case. The AMHP is supposed to look at the case from a "non-medical perspective" but in fact there is virtually no scope for him/her to do so. The AMHP has to address the same four conditions as the two doctors, but these conditions are almost entirely medical, and as with the ASW in the present Act, the AMHP would be on very shaky legal ground if he disagreed with the doctors on purely medical issues. The only scope the AMHP would have for exercising any kind of independent judgement would be in respect of the degree of risk.

I have looked only at the entry criteria for assessment , but the same criteria apply at the Tribunal stage, so the Tribunal will labour under the same difficulty, that it will have no discretion *not* to make an order if the four conditions are met, and will be able to exercise discretion only about the content of the care plan. Tribunals (and examiners at the initial stage) will be able to mitigate the pernicious effects of this legislation only by using the one major area of discretion still available, which is to make the treatment "non-resident." I think, therefore, that contrary to earlier predictions, there will be a very widespread use of community orders, by examiners and Tribunals who do not wish to impose compulsory powers at all but who have no choice because the law gives them no discretion.

The only part of the Bill on which they could possibly rely is Clause 1(3), the "general principles" which require them to have regard to the need "to keep to the minimum necessary to protect their health or safety or other persons, the interference to patients in providing medical treatment to them and the restrictions imposed in respect of them during that treatment." However, all that this convoluted phraseology means is that where compulsion is necessary, they should seek, in Larry Gostin's phrase, "the least restrictive alternative," and it cannot be read as giving support to the non-use of compulsory powers where the four conditions are met.

So where does social work stand in all this ?

I am absolutely clear that, taking into account the entry criteria and all the other aspects of the draft Bill, **the AMHP is not a social work role.** It is purely an administrative and enforcement role in support of the doctors and the Trust; it does not permit the AMHP to take into account those factors which ought to inform any decision by a social worker, and it contains no significant element of the discretion which is an essential element of any professional role. Any social worker acting as an AMHP would be effectively acting as hired muscle for the Secretary of State, and would certainly be in breach of the BASW Code of Ethics and the GSCC Code of Conduct. If it is not a social work role, it should also be excluded from the terms of BASW's indemnity insurance, and **the only logical position for BASW to take is to advise its members, and all other social workers, to boycott it entirely, and to recommend to the GSCC that it should be declared incompatible with registration.**

Roger Hargreaves

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