

BRITISH ASSOCIATION OF SOCIAL WORKERS

Briefing paper on the Mental Health Bill 2006

BASW's overall view

As a core member of the Mental Health Alliance, we fully support the Alliance's stance, that this Bill reintroduces many of the most unacceptable proposals in the abandoned 2004 Draft Bill, whilst failing to address many of the weaknesses of the current legislation. The government's agenda continues to be driven by media reports of homicides by people with a mental disorder, despite the fact that none of the subsequent inquiry reports has ever identified a lack of adequate legal powers as being a significant factor.

BASW's particular concerns

Within the context of the wider Alliance campaign, our specific concerns about the Bill are about those parts of it which have the most direct implications for social workers. These are:

- the Approved Mental Health Professional (AMHP)
- Supervised Community Treatment
- the provision for obtaining a warrant "to search for and remove patients"
- the "Bournewood" provisions which will amend the 2005 Mental Capacity Act.

In conjunction with the National ASW Leads Network, which represents the immediate line managers of Approved Social Workers (ASWs) and those responsible for training them, we will be promoting a series of amendments on these issues.

The Approved Mental Health Professional (AMHP)

The government's main proposals:

- The role of the present Approved Social Worker (ASW) in making applications for compulsory admission under the Act will be opened up to members of health professions (who would mainly be nurses)
- Local authorities will continue to be responsible for the selection, training, approval and deployment of AMHPs as they are for ASWs at present; however, in order to enlarge the pool of potential recruits, AMHPs will not be required, as are ASWs at present, to be "officers of the local authority" but instead will "act on behalf of the local authority."

- The present duty on local authorities to appoint a “sufficient number” of ASWs will be removed and be replaced with a duty to “arrange for an AMHP to consider” any case where it appears to the authority that an assessment for compulsory admission may need to be made.

BASW’s position:

- Whilst we have reservations about the ability of at least some health professionals to provide the independent, non-medical perspective which ASWs bring to decisions about the use of compulsory powers, we recognise that it has not been possible for local authorities in many areas to recruit enough social workers, and that it is therefore reasonable to make provision for members of other professions to be recruited if this is necessary in order to ensure sufficient numbers. We are reassured that the government seems willing to leave the recruitment process entirely in the hands of the local authorities, and that it forecasts only a very gradual introduction of health professionals.
- We support the removal of the “officer” requirement, which will allow local authorities to recruit from a wider pool of experienced social workers in the private and voluntary sectors as well as from health professionals employed by NHS Trusts. However, the wording of the alternative provisions in the Bill is incompatible with the long-established principle, confirmed by recent caselaw, that the holder of this role is an “independent public body” whose decisions cannot be countermanded by the local authority.
- We support the proposal that the local authority should “arrange for an AMHP to consider” a case. However, as drafted, this provision would not require a speedy response and we think that it should be amended accordingly and that the requirement to appoint a “sufficient number” of AMHPs should be retained. Whilst the recruitment problem has to some extent mirrored the situation in social work generally, a number of local authorities have neglected their ASW services, safe in the knowledge that they are not included in the national performance-rating system, as a result of which staffing levels have fallen dangerously low.

Additional concerns.

BASW has concerns about a number of aspects of the operation of the present Act, which have not been addressed by the amendment Bill. If this is intended to be more than just a temporary “sticking-plaster” pending a thorough revision of the legislation, it is essential that these issues are dealt with at this opportunity.

In particular:

- Recruitment of NHS-employed health professionals as AMHPs will further exacerbate the erosion of independence from the hospital and the doctors which is already occurring as a result of the secondment or transfer of ASWs to Mental Health Trusts. The ASWs are technically still employed by the local authority whilst acting in their statutory role, but in many cases, their managers have also been seconded or transferred to the Trust and so the independent role of local government in the compulsory admission process, which has been a basic element of that process since 1959, is becoming largely an illusion.

- As a result, the process no longer meets the current human-rights standard for the making of decisions involving loss of liberty, in that the two most powerful decision-makers - the ASW and the consultant psychiatrist - may well be close colleagues in the same team and both responsible to the Trust which runs the hospital to which the patient will be admitted. The government acknowledged this at the beginning of the review of the legislation in 1998, and its solution was to require all initial decisions to be confirmed by an early Tribunal hearing. Now that this proposal has been abandoned, it is essential that corrective action is taken to ensure that the process meets accepted standards for impartiality and objectivity.
- As part of this, the legal position of AMHPs needs to be strengthened to protect them from improper influence from Trust managers or more senior Trust colleagues. The government dismisses this concern, saying that “the ability of a mental health professional to be independent stems from their professional status, training and ability. It does not stem from whom their employer is.” However, the professional status within the organisation of the relatively-junior social workers, nurses and occupational therapists who are likely to be acting as AMHPs will be vastly less than that of the consultant psychiatrists, some of whom will be carrying senior management responsibilities. Many seconded ASWs already report that they have come under great pressure to act, or not to act, in a particular way, and members of health professions are likely to be more vulnerable to such pressures.
- A contributory factor to the ASW recruitment problem has been that ASWs are facing increased risks to their health and safety (and to that of patients and their carers) due to the shortage of beds and difficulty in getting assistance from police and ambulance services, none of which were issues when the present legislation was framed. The stress on the ASW is compounded by the fact that they, not the local authority or the Trust, are personally responsible for the safety of the patient (and of others who might suffer harm) until they have been received onto a hospital ward, and that they are legally very vulnerable given that they act as “independent public bodies” and can be (and are) sued in their own right. Logically, once an application has been made, the legal responsibility for the transporting and safe custody of the patient should pass to the Trust. Unless this issue is dealt with, it will continue to be difficult to recruit and retain sufficient competent people regardless of the opening-up of the role to other professions.
- The difficulty in getting assistance from the police in particular has highlighted uncertainties about the rights of entry of both the police and ASWs to private premises, and has resulted in excessive use of the provision in Section 135 of the Act to obtain a magistrate’s warrant (see below.)
- Whilst we welcome the removal of the “officer” requirement, this has a number of legal consequences which need to be addressed. In particular, if the ASW at present decides not to admit the patient, he or she has a duty which arises from officer status to assess and if necessary to make arrangements for the provision of alternative community care services, but a non-officer AMHP, who might be self-employed under contract, would be legally entitled simply to walk away.

What BASW is looking for.

We are looking for the amended Act to:

- provide an enforceable means of ensuring that there will be “sufficient numbers” of AMHPs
- ensure that AMHPs are, and are seen to be, independent of the doctors and the hospital, that their decisions cannot be overruled by the local authority, and that they are able to exercise their professional judgement free of improper influence
- ensure that the role of the local authority as the provider and guarantor of an independent AMHP service is more than a nominal one
- restore to the compulsory admission process the quasi-judicial standards of impartiality and objectivity which are required by current human rights standards and which were inherent when it was originally drafted
- address the legal implications of the shortage of beds and the difficulties in getting police and ambulance assistance and limit the AMHP’s legal vulnerability in these situations
- clarify the position on powers of entry for police and AMHPs
- ensure that AMHPs who are not officers of the local authority have a duty to arrange alternative services if they decide not to admit the patient to hospital.

Supervised Community Treatment (SCT)

The government’s main proposals:

- It will be possible for anyone who is detained in hospital for treatment under Section 3 of the Act to be discharged subject to the terms of a Community Treatment Order (CTO). This will be made by the responsible clinician with a concurring opinion from an AMHP.
- The CTO will state conditions, which may include requirements to receive medical treatment or to “abstain from particular conduct.” The conditions must be agreed by the AMHP.

BASW’s concerns

- We support the introduction of CTOs, but only in respect of a very limited group of patients, the so-called “revolving door” patients, that is patients who have a history of repeated admissions followed by failure to persist with treatment after discharge. However, although the government stated that this was its intention, neither the Bill nor the draft Code of Practice includes any such limitations.
- The AMHP who gives the concurring opinion may be a close colleague of the responsible clinician in the multi-disciplinary team which is proposing the action, and indeed may be the patient’s own care co-ordinator; there is no requirement for any impartial,

disinterested opinion despite the fact that this is a major infringement of personal liberty which can last for up to six months before renewal.

- The conditions once set can be suspended or varied without further reference to the AMHP, and whilst the draft Code cautions against it, this could be done even if they had only recently been agreed and the circumstances had not substantially changed.

What BASW is looking for.

- Criteria on the face of the Act which specify the number and frequency of previous admissions before the power can be used
- A requirement that the AMHP giving the concurring opinion must come from a different clinical team
- A requirement that any change in conditions imposed must be confirmed as soon as possible by an opinion from an AMHP.

Obtaining a warrant to “search for and remove patients.”

The current position

Under Section 135 of the Act an ASW can apply to the magistrates’ court for a warrant to allow forcible entry to premises where “ there is reasonable cause to suspect that a person believed to be suffering from mental disorder has been, or is being, ill-treated, neglected, or kept otherwise than under proper control....or being unable to care for himself, is living alone in any such place.” The government is not proposing any change other than to replace the ASW by the AMHP.

BASW’s concerns.

This section is based on Section 14 of the 1890 Lunacy Act and Section 15 of the 1913 Mental Deficiency Act, and is virtually the last surviving fragment of C19th mental health legislation. Neither its language nor its criteria bear any relation to the usage of the 1983 or the 1959 Acts, but this was not a major issue even in 1983 since it was so rarely used, and when it was, the warrant was usually issued by a single magistrate without hearing detailed argument. However, it is now far more frequently used, and applications have to be made in court with a requirement to present formal evidence and to explain how the circumstances fit the statutory criteria.

What BASW is looking for:

Amendment to remove the outdated and stigmatising language and to reflect the current grounds for assessment under the Act, and (in conjunction with clarification of the general

powers of entry of AMHPs and the police) to make it clear that this power can be used only where forcible entry is necessary.

The “Bournewood” provisions

These provisions are designed to put into statutory effect the House of Lords judgement in the “Bournewood” case, by providing a framework to authorise “deprivation of liberty” of people in hospitals and care homes who are effectively detained but who lack capacity and who are not resisting. The powers will be contained in new schedules of the 2005 Mental Capacity Act, but the amendments are included in the Bill to amend the Mental Health Act.

BASW’s concerns.

We support the government’s scheme in principle, and in particular we support the placing of these powers within the Mental Capacity Act (MCA) rather than the Mental Health Act (MHA). However, we have serious concerns about the way in which the government is proposing to implement these powers, and we believe that its present scheme would be unworkable in practice. Specifically:

- Its estimate of the numbers of people who would need to be assessed annually is not based on any rigorous research and appears to be little more than a “politically-convenient belief.” The estimates of those with experience in the field tend to be much higher.
- Despite explicit warnings on this issue in the report of the Joint Scrutiny Committee, it has given insufficient thought to the compatibility of these proposals with mental health legislation. They are effectively parallel provisions to those contained in Parts I and II of the MHA (which deal with civil detention) and will need to be operated in tandem with them. It will (as the draft MHA Code of Practice acknowledges) be impossible to make a decision to detain under the MHA without first discounting the use of the less restrictive MCA powers, and logically the reverse will also apply, that the MCA “assessors” will need to satisfy themselves that the MHA powers are not needed. This means that in practice, assessments under the two Acts will need to take place simultaneously; however, as presently drafted, the MCA scheme would make this extremely difficult.
- The MCA provisions will also need to be operated largely by the administrators and professionals who already operate the MHA. Although the government is saying that sufficient funds will be made available to fund a completely new “parallel workforce” of MCA assessors, it is totally unrealistic to think that such a workforce could be recruited, given that the qualities required to operate both Acts are essentially the same and are

already in desperately short supply; and in addition, as pointed out above, assessors will need to be qualified to assess simultaneously under both Acts. However, the officials responsible for the Regulatory Impact Assessment were working on the assumption that the two workforces would be largely separate, and so the figures set out take no account of the additional workload on those already operating the MHA.

- The scheme as set out in the draft Schedules 1A and A1 of the MCA is excessively complex and bureaucratic and is drafted in a very similar style to the abandoned 2004 Draft Mental Health Bill which was criticised by the Joint Scrutiny Committee as being “difficult to read and to follow.” The schedules alone extend the length of the MCA by 40% and are almost as long as Parts I-II of the MHA (which provide for not just one but a whole series of separate powers), yet much of the detail is left to regulations which have not yet been published. The complexity of these provisions is completely disproportionate to the nature of the powers involved, and would be a considerable burden on those required to understand and to implement them, a problem made much worse by the government’s decision to create two separate supervisory bodies - the PCTs and the local authorities - performing virtually identical functions.
- Despite all this, the provisions fail to guarantee vulnerable people lacking capacity the most valuable safeguard, which is immediate access to an independent professional advocate. This would clearly be expensive, and the government’s preferred approach seems to be to try to draft relatives and friends into taking on formal roles which can properly be carried out only by paid advocates and which are incompatible with a close personal relationship.

What BASW is looking for

A study should be commissioned to produce a much more reliable estimate of the number of assessments and determinations likely to be needed, and the workforce implications should be re-evaluated on the assumption that the same group of professionals will be largely responsible for the operation of both Acts.

It would be quite impossible to remedy the defects in the statutory proposals by way of selective amendments. The draft Schedules 1A and A1 of the MCA should be withdrawn and the whole scheme should be drastically simplified, paying particular attention to the need to ensure compatibility with the Mental Health Act. Any money saved from a reduction in unnecessary bureaucracy should be invested in expansion of the IMCA (Independent Mental Capacity Advocate) Scheme.

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