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directors of adass
adult social services

MENTAL HEALTH, DRUG & ALCOHOL POLICY NETWORK

BULLETIN 12 – 5 November 08

Special Bulletin Celebrating the Role of the Approved Social Worker

Foreword

Welcome to this special celebratory edition of the ADASS MH, D&A Policy Network Bulletin. Its intention is to remind members what fantastic work ASWs have delivered over the past 25 years, using illustrations including 'a day in the life' from Greg Slay, ADASS Lead on the Mental Capacity Act and commentary from Roger Hargreaves on some of the challenges faced in implementing the role. ADASS MH, D&A Policy Network formally wishes to thank ASWs for all their commitment and hard work and looks forward to the new AMHPs continuing this trend.

A potted history

The Lunacy Act 1890 legislated for the care and treatment of individuals suffering from mental health disorder and made arrangements to protect their estates. It also regulated the asylums, a number of which had already existed for several centuries.

The Mental Treatment Act 1930 did four things; it reorganised the Board of Control, it made provisions for voluntary treatment; it gave an official blessing to the establishment of psychiatric out-patient clinics and observation wards; and, in line with the Local Government Act of 1929, it abolished out-moded terminology and brought the official expressions used in conjunction with mental illness more into line with the modern approach to the subject.

The Mental Health Act 1959 followed the main recommendations of the Royal Commission on the law relating to Mental Illness and Mental Deficiency. The Commission also sought to remove "certification" in the hope that the public would no longer stigmatise or label detained people. Local health authorities were given redefined powers to provide training and occupation, as well as residential accommodation; the appointment of mental welfare officers and the supervision of private homes for mentally ill people. These health authority functions were assigned to local social services authorities by the **Local Authority Social Services Act 1970**.

Following publication of the outcome of a wide consultative process in 1978, a series of consolidating measures were effected, resulting in the **Mental Health (Amendment) Act 1982**. This made substantial amendments to the 1959 Act as well as introducing new powers relating to the care, treatment and discharge of mentally disordered patients. The 1982 Act was then consolidated into the **Mental Health Act 1983**. The most significant elements of the new 1983 Act included:

- the replacement of 'voluntary' admission by the term of 'informal' admission;
- the emphasis on the least restrictive alternative to hospital - thus reinforcing the need to use, and develop, community-based services for care and treatment;
- the legislation of duties relating to after-care;
- the development and enhancement of the training of Approved Social Workers (replacing Mental Welfare Officers) in the assessment of mentally disordered people under the Act, from 1984.

In **1995 a Mental Health (Patients in the Community) Act** was incorporated with S.25A-H of the 1983 Act, following concerns expressed in the 1994 Christopher Clunis Inquiry Report.

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Challenges along the way…from Roger Hargreaves, BASW Mental Health Lead

Roger Hargreaves was vice-chair of the BASW committee which originated the ASW proposals in 1977. The committee suggested the title as a means of establishing parity of status with the Approved Doctor, although the secondary aim of achieving parity of remuneration never quite came off. The status of the generic MWOs had sunk very low, and there was a lot of ground to make up, an objective which was not helped by the fact that most of them, backed by NALGO, were anti-elitist and resistant to any kind of competence assessment, which was the core of the BASW proposals, it's ironic that BASW was attacked more recently by ASWs (including some of the same people, it is thought) for not defending the exclusive status of social work's most successful elite!

And the future…

In the late 1990s the Government attempted to introduce replacement mental health legislation but was unsuccessful in realising this until 2007. As evidence began to build of a national shortage of ASWs (see for example: Huxley, Evans, Webber and Gately, 2005) plans were put in place to extend the role to other professionally qualified staff working in integrated mental health services. The Approved Mental Health Professional (hereafter, AMHP) role replaces the role of Approved Social Worker, with effect from 3rd November 2008, when the (hotly contested) **Mental Health Act 2007** revisions to the Mental Health Act 1983 come into force.

AMHPs need no longer have a professional qualification in social work. They may be professionally qualified in the disciplines of mental health or learning disabilities nursing, occupational therapy or psychology. However they must undertake an accredited AMHP training course provided at a higher education institution, and on completion of that course be able to demonstrate their competence to practise in the role.

Unlike Approved Social Workers, persons providing the new role of AMHP need no longer be officers employed by a local social services authority. However it will be on behalf of a local social services authority that they undertake their duties under the Act. It is the task of the Appointment Panel in each local social services authority to be satisfied that all AMHPs working on behalf of that organisation are competent to act in that role.

AMHPs are carrying out statutory functions of a public nature. All work undertaken by an AMHP within the context of the Mental Health Act must be consistent with respecting the human rights of all individuals, which are set out in the European Convention of Human Rights.

Where AMHPs undertake Mental Health Act assessments on behalf of a local social services authority, that organisation is required to:

- Ensure that all AMHPs have access to professional supervision and support in their role;
- Provide a minimum of 18 hours of refresher training, relevant to the AMHP role, each year;
- Provide for the health and safety of AMHPs whilst they are undertaking assessments on its behalf;
- Provide for scrutiny of the professional competence of AMHPs, and for appointing, re-appointing, removing or suspending AMHPs as necessary;
- Provide legal indemnity for AMHPs whilst they undertake the role; and to
- Provide access to legal advice whilst AMHPs carry out their Mental Health Act assessment duties.

A day in the life…

by Greg Slay

(This article was first published in 2002 in Social Scene, the Newsletter of West Sussex Social and Caring Services, Issue 12, page 12. Copyright rests with West Sussex County Council).

I had quite a busy Saturday recently whilst on call with the Out of Hours Emergency Service. I am one of two Approved Social Workers available each session to be sent out on emergency community care assessments or assessments under the Mental Health Act. There is also a childcare social worker on-call.

On Saturdays and Sundays it is a 24 hour session from 9am to 9am. The duty manager screens all emergency visits first and, at 9.15am, he rang to ask me to sort out some arrangements left over from the previous day. This involved moving a patient, detained under the Mental Health Act (MHA) on an assessment order, from a residential care home in Burgess Hill to a hospital in Bognor Regis. This necessitated going over to Burgess Hill, which is about an hour's drive from my

home, and then co-ordinating the transport arrangements with Sussex Ambulance Service. The ambulance eventually arrived around midday, at which point the patient was less than keen to get into it, so further persuasion was needed. I then followed the ambulance across West Sussex to Bognor Regis.

After the patient was admitted to the hospital in Bognor Regis, I was contacted again and asked to go to Horsham Hospital to assess another patient who was detained under a holding power under the MHA. This second patient had a diagnosis of paranoid schizophrenia and firmly believed that the nursing staff wanted to electrocute her. She also thought that the purpose of my visit was to assess the availability of her body for medical research purposes. I made an application for her to be detained on a treatment order. Shortly before I left the ward, one of her relatives came to visit, and I then spent a further 40 minutes explaining to him what was happening, and what support he probably needed in the community for himself as a carer.

En route home I was contacted again on my mobile telephone by the duty manager. He requested I liaise with a visiting psychiatrist, who was advised to consult me for appropriate guidance about a West Sussex resident who had been admitted to a private hospital in Surrey with depression earlier on in the week. As the patient was now refusing to take ay food or drink, the psychiatrist wanted to discuss whether or not she should be detained under the Mental Health Act. I then phoned the psychiatrist, discussed the various legal and professional options with him, and in due course agreed that an assessment under the MHA was warranted. I then alerted the patient's nearest relative and suggested that he might like to be involved. As the visiting psychiatrist has a financial interest in the hospital where the patient is detained, he is legally prevented from providing one of the medical recommendations. In view of the fact that the patient was in a hospital in Surrey, I also contacted the Surrey Out of Hours Service, who agreed to take the case.

I returned home at 8pm having travelled 149 miles, had something to eat, and wrote up my papers. At 10pm I was called out again, this time to Worthing police station where I was asked to act as an Appropriate Adult (PACE - Police and Criminal Evidence Act, 1984) for a 40 year old black Nigerian man from Bognor Regis, with a history of schizophrenia. I had to wait over an hour for the duty solicitor to turn up to 'take instructions' from the Nigerian.

During that time (11pm to midnight) I was able to see at first hand Worthing police station's 'custody suite' on a Saturday night and the succession of police vehicles arriving with people under arrest.

During the interview with the duty solicitor, in advance of the proposed PACE interview, the Nigerian described the person he had been harassing as his wife, but then said that his wife used to be black, but the person in Bognor was white. The duty solicitor asked the Nigerian to describe, in his own words, the other two people present in the room. The Nigerian said that he knew who the duty solicitor was, and said that I was his uncle, although I too had changed my skin colour from black to white. At this point the duty solicitor terminated the interview and we agreed that the Nigerian needed to be seen by a forensic medical examiner (FME), with a view to a Mental Health Act assessment.

The custody sergeant queried whether I could do the job that was expected of the FME. I explained to him that I was not medically qualified to do so, and that the Mental Health Act Code of Practice and the Act itself, specifically requires a person with a mental disorder in a police station to be examined by an experienced medical practitioner.

I left the police station just before 1am, having roused the duty manager from his sleep to advise him that the PACE interview was not proceeding at this point. I explained to the duty manager that the FME was expected to turn up at some point during the night, not only to see the Nigerian but to see five other people who were waiting for medical assessment. The reason why the FME was not at the police station was that there was only one FME on duty for the entire area between Eastbourne and Worthing. At this stage, Brighton police station had a 'full house' waiting for him! I was not contacted again later in the early hours, and it is likely that my colleague, who came on duty at 9am on Sunday, dealt with the pending Mental Health Act assessments.

International approaches

No other country is understood to be have a comparable role with the exception of Scotland. Most other jurisdictions have court-based systems, which the Scots had to a large extent until 2004. Very often, as again with the old Scottish system, doctors and police will have emergency powers pending a court hearing, and we are not aware of any jurisdiction which has a social worker in that role. Some international studies were done in connection with the legislative reform, but these mainly concentrated on CTOs and which did not look at admissions processes.

Get involved

Special meeting on safeguarding – 2nd December, London

The network is holding a special meeting on 2nd December in Local Government House on ‘Safeguarding’. Peter Hay, of Birmingham City Council (who also sits on the ADASS Management team) will be running this session and we encourage

members to attend. A detailed agenda will be distributed closer to the event. Please contact elizabeth.murray@hants.gov.uk if you haven't already and would like to attend.

Invitation to be on Focus Groups for the assessment of risk of different services – 18 November, location tbc

The DH is holding a series of workshops on the assessment of risk in different services. ADASS MH, D&A would like to nominate a member to attend the one on the 18 November. Please see the invite for more details and contact Richard.webb@telford.gov.uk or Christina.Heap@nhsconfed.org if you are interesting in attending on behalf of ADASS.

Mental Health Social Care Strategic Network – Invitation to join

In 2001 Professor Antony Sheehan set up the NIMHE Learning Set for Directors of Social Care who had transferred from local authorities to mental health trusts, and found themselves somewhat isolated. See extract from the British Journal of Leadership in Public Services - Leading and Learning.

In 2003 Bill Kilgallon, then CEO of SCIE ,funded a second set for managers in trusts with responsibility for social work services. The sets also took in commissioning managers from LA's in Mental Health.

Over the years the sets have provided a source of development, support, and mutual learning leading to policy development.

The learning sets have now turned into a National Strategic Network, with Hari Sewell, from Camden and Islington as Chair, and we pleasure in sending you the network details plus invoicing information.

Other news and information

ADASS South East developing a good practice inter-authority ordinary guidance on DOLS

"The DH has begun work on revising the LAC (93)7 with the expectation that it will consult on the 'Directions' that will set out the process local authorities should follow in order to resolve disputes. As well as taking account of relevant provisions in the Health and Social Care Act 2008, it is likely that the revised guidance may address a number of policy areas that have come into force since the '93 circular.

Following agreement at the ADASS National Executive Council on 4 September a short-life Local Authority Reference Group has been established with the aim of developing a single operational inter-authority ordinary protocol for England. This group will work alongside the DH Working Group."

Landmark report published on World Mental Health Day

http://www.info4local.gov.uk/filter/?item=990831

Regards

Jenny Goodall, Richard Webb & Lucy Butler