

“A Mere Transporter” - the Legal Role of the Approved Social Worker

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Introduction

The role of the Approved Social Worker in the 1983 Mental Health Act is an unsatisfactory amalgam of legal, professional, administrative and practical functions which has accumulated on a largely *ad hoc* basis over the last two centuries. The current review of the legislation offers an opportunity to redefine this role in a way which is both clear and internally consistent. This article reviews the history of the role and suggests that more fundamental changes are needed than the proposed in the Report of the Expert Committee.

The issues

Under the civil provisions of the 1983 Mental Health Act, virtually all applications for admission are made by Approved Social Workers (ASWs), who are required by Section 114 to be appointed by local social services authorities and to have “appropriate competence in dealing with persons who are suffering from mental disorder”- which means in practice that they must be qualified and experienced social workers who have undergone a course of additional training prescribed by the Central Council for Education and Training in Social Work.

However, whilst the Expert Committee chaired by Professor Geneva Richardson received “strongly voiced arguments...in favour of retaining the ASW as the applicant” in a new Act, it noted that “some respondents suggest that other mental health professionals are as capable of independence as ASWs whatever their employment status” and recommended that “consideration be given to the gradual extension of the role of applicant to include other mental health professionals who are not psychiatrists.”¹ In practice “other professionals” would mean the Community Psychiatric Nurses (CPNs) employed by the Trusts, who have over the last twenty

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1 *Department of Health 1999, “Report of the Expert Committee: Review of the Mental Health Act 1983” paras. 5.11 - 5.13.*

years progressively replaced social workers as the major professional group in the community mental health services; this, plus an increasing difficulty in recruiting ASWs, suggests that a transfer of their statutory role to CPNs would be the next logical step. However, this raises the questions, first, as to whether there is any intrinsic merit in this role continuing to be performed by employees of local authorities as opposed to the NHS, and secondly, whether it is a role which *ought* to be perpetuated in the new Act, at least in its present form.

The history

The genesis of the role can be found as far back as 1808, in the County Asylums Act which gave the Justices of the Peace the power to build asylums to house “pauper lunatics.” The parish Overseers of the Poor were given the task of identifying those considered to be lunatics, bringing them before the Justices and obtaining a warrant, arranging transport to the asylum and making provision from parish funds for their upkeep. From that point on, the role can be traced as a continuum right through to the present day, albeit that it has undergone as many metamorphoses as Dr. Who; from ASW to CPN would be the sixth such transformation.

The Overseers in due course became Relieving Officers, and the mass of mental health legislation was finally consolidated in the 1890 Lunacy Act, which, repeatedly and heavily amended, remained the basis of mental health law until 1959. The central figure in the 1890 Act was the Justice; since a finding of lunacy often led to disinheritance, the middle classes had become alarmed about the possibility of collusion between grasping relatives and their private medical attendant, and so the Justice’s role was extended to include private patients.² The Relieving Officer’s duties however, continued to relate only to pauper patients and to “persons found wandering” (although these two groups would have made up the vast majority of patients dealt with under the Act - then as now, the association of mental illness with poverty and homelessness was very strong.)

In an emergency the Relieving Officer could, under Section 20, detain on his own authority for up to three days, but in other circumstances he would, when he “had knowledge that any pauper... is deemed to be a lunatic” and that there was no relative able or willing to take action, bring that person before the Justice (or more commonly, bring the Justice to the person.) It was then the Justice’s responsibility to obtain a medical opinion, usually from the GP or Poor Law Medical Officer, before signing the “certificate” which gave authority for the Relieving Officer to convey, and for the asylum to admit and detain; as often as not, however, the sequence was reversed, with the doctor, as the first on the scene, initiating the process and requesting the Relieving Officer to make an application to the Justice.

In its essentials, this whole process would still be familiar to a modern ASW with the exception that a psychiatrist, not a Justice, is now the third party; but the Relieving Officer was a very different animal to the modern social worker. In the one office (and in many rural areas, the one *person*) he combined the functions of a large chunk of modern local government, the Benefits Agency, and the NHS - in his practice manual the guidance on mental health matters is sandwiched between regulations for “outdoor relief” and burial of the pauper dead, and a chapter on acting as a census enumerator, infectious diseases in lodging houses and procedures for- vaccination.³

2 Jones, K. 1972 “A History of the Mental Health Services” Routledge.

3 Hadden’s Relieving Officer’s Handbook, 1935 edition, Chapter XI

He exercised most of these multifarious powers as a statutorily designated official rather than as a mere agent of his employing Poor Law Union, and it was therefore entirely logical that he should also act as an individual under the Lunacy Act and be personally liable at law. However, in 1929 the Poor Law functions were transferred to local authorities, where the legal traditions were very different; local government officers are faceless beings acting solely on behalf of their chief officer, who in those days would have signed every letter and memo, although the Relieving Officers for the time being retained their statutory designation.

This transfer also brought the Relieving Officers into contact with the health departments, which in the most progressive local authorities were taking the first tentative steps towards the development of community services for people with mental health problems by appointing “Mental Welfare Officers” (MWOs); and it meant that, for a brief period, the Relieving Officers and the mental hospitals were accountable to the same body, the asylums having been taken over by the new local authorities in 1889. In a few places psychiatrists held joint appointments in the hospital and the health department, thus bringing about a temporary fusion of hospital and community services.⁴

The potential of such arrangements was, however, never developed, as war intervened and then, in 1948, the hospitals were transferred to the new National Health Service; at the same time, the Lunacy Act was amended yet again, and with the abolition of the Poor Law the mental health duties of the Relieving Officers were transferred to “Duly Authorised Officers” (DAOs) in the local authority health departments.

If you believe the media, community care of the mentally-ill began in 1993 and has been a disaster; in fact, it began in 1948 and has been, on the whole, a success. It started slowly, however, but gathered speed during the late 1950s. At first, the DAOs were mostly ex-Relieving Officers, and they continued to combine their statutory mental health role with other administrative duties, but in time the role began to be combined with that of the Mental Welfare Officers, many of whom had trained as psychiatric nurses; in Lancashire by 1953 only one-third of the MWOs had begun their careers as Relieving Officers.⁵ The DAOs/MWOs were not, however, yet seen as “social workers;” a Psychiatric Social Worker, (PSW), postgraduate-trained and working mainly in hospitals and clinics, was an altogether superior being, and when, during the hearings of the Percy Commission in 1955, Lord Percy inadvertently confused the two he was sharply corrected by a doctor - “the PSW is in a class apart; they are a very special group of people. The name is a trademark, and you must not call anybody else a PSW.”⁶

This kind of attitude permeated the Commission’s deliberations as to the role which the DAO/MWO ought to play in the proposed replacement for the Lunacy Act. It was stressed at great length, even by the DAOs themselves, that they were almost entirely subservient to the doctors, although everyone knew that the reality was very different; GPs had virtually no training in psychiatry, whilst the DAOs had vast practical experience - for instance, in Liverpool each DAO carried out an average of 96 compulsory admissions a year,⁷ whilst the average GP would be involved in perhaps three or four, and the GPs were therefore heavily reliant on the DAO’s advice.

4 Jones, K. *supra*

5 Jones, K. 1961 “Mental Health and Social Policy” p.161, Routledge.

6 HMSO 1957 Royal Commission on the Law Relating to Mental Illness and Mental Deficiency, Minutes of Evidence, Q5383

7 *Ibid.* Q4916

However, even the most ignorant doctor was officer-class, whilst the DAOs were, at best, mere sergeants, and the medical witnesses to the Commission were appropriately patronising:

Lord Percy: "I confess the name Duly Authorised Officer rather puzzles me. For half the time he is a mere transporter, and that is how he is usually thought of.....on the other hand, he has certain independent duties to watch over the safety of the public.....and the two functions do not really fit in together?"

Doctor: "He does ...other things...he prepares the documents...I think one always feels a little doubtful about it, but....they do their work very well on the whole. They are quite an intelligent crowd of people."⁸

The Commission struggled with this contradiction that the "mere transporter" had independent legal powers, even though "statutory designation" had now ceased and he was in all other respects just an ordinary local government officer. Under Section 14 of the original Act he had not been required to exercise any personal judgement as to the alleged lunatic's state of mind before calling in the Justice - it was "sufficient if by common report the person is a lunatic whether he is in fact one or not"- but in 1946 Section 14 was amended to require him to have "reasonable ground for believing that a person....is a person of unsound mind" before taking action, and it was later confirmed by caselaw⁹ that this required him to exercise at least a degree of personal judgement, especially in the case of Section 20 where he acted alone (and so convenient was this procedure than in 1955 it accounted for 27 % of all compulsory admissions.)¹⁰

In the event, however, the Percy Commission saw no use for this personal judgement in the new order of things, in which the doctors would be in the ascendant. It recommended that the DAO should become in law what by that time he usually was in practice, a Mental Welfare Officer, but that in the process he should "lose the greater part of his powers, becoming now merely a substitute for the nearest relative as the applicant for admission. Since the nearest relative could not be expected to exercise any professional judgement, nor therefore could the MWO, and he was no longer required to have "reasonable grounds" before acting, the application being "founded on the medical recommendations," with no recognition that there might be any social dimension to the question of compulsion.

However, it was agreed that the MWO should retain a degree of independence, anomalous though it now was, although this was seen purely as a "conscience clause" rather than as a licence to defend the patient's civil rights:

"(A psychiatrist and the patient's GP) are better qualified than anyone to diagnose the patient's medical condition, to assess his need for treatment, and to judge the probable effect if treatment is not provided. No responsible....MWO would lightly disregard or dissent from their advice...(but) if an MWO is asked to take the responsibility of signing an applicationhe must in the last resort be free to do so."¹¹

8 *Ibid.* Q758

9 *Buxton v. Jayne* (1960) 1 W.L.R.783

10 *Cmdnd 169, Report of the Royal Commission on the Law*

Relating to Mental Illness and Mental Deficiency, 1954-57 Appendix IV

11 *Cmdnd. 169 Ibid. para 404*

The MWO did not, however, in practice revert to being a “mere transporter” under the 1959 Mental Health Act. As previously, his actual status vis-a-vis the other participants was far higher in practice than in legal theory, and although the paperwork was now much simpler and many relatives could deal with it, he (and now occasionally she) was rarely cut out of the admission process altogether; - his expertise as “crisis manager,” co-ordinating doctors, ambulance and police, was far too valuable to be dispensed with, and in return he could expect his advice to be taken seriously. This status was reinforced by the rapid development of the community services after 1959; the number of MWOs trebled in ten years, and by 1967 there were 1,500 of them, nearly one-quarter holding social work qualifications (including an increasing number of PSWs and at least as many more being qualified psychiatric nurses).¹²

Training had been seen by the Percy Commission as being likely to induce greater conformity with medical opinion, the British Medical Association suggesting, (on the basis presumably that disagreements between doctors and laymen are always due to ignorance on the part of the latter), that the MWOs should be given “sufficient training that they will not want to over-ride the opinion of an experienced psychiatrist.”¹³ In practice, of course, what happened was the exact opposite, since training caused the MWOs to identify with the emerging profession of social work, and the willingness of MWOs to stand their ground was bolstered also by their central role in the expanding community mental health services.

This was on the whole a constructive tension, since the MWOs were accepted, albeit sometimes patronisingly, by psychiatrists as being experts in their own field. However, in 1971 they were transferred from the Health Departments to the new Social Services Departments, and their duties were progressively taken over by “generic” social workers, often social science graduates, who had little or no mental health experience, but who had absorbed the notions of the “anti-psychiatry” school of sociology and who seized on their powers under the Mental Health Act as a means by which they could defend the labelled and stigmatised from the reactionary medical profession. Not surprisingly, relations deteriorated, and many psychiatrists chose instead to use the nearest relative as applicant, thus exposing the weakness of the MWO’s legal position.

The present law

In 1975 the government commenced what was to become a very protracted review of the 1959 Act, the tone of which was set by MIND’S Legal Officer, Larry Gostin, who in his report “A Human Condition”¹⁴ launched a well-researched assault on the supposed infallibility of psychiatrists, and their tendency to interpret the Act for their own convenience at the expense of the patient’s rights. He noted the weakness of the MWO’s legal position, which rendered them powerless to resist these abuses, and argued that as a counterbalance to medical opinion “the social worker should make an independent evaluation of the prospective patient...(focussing on) the person’s family and community environment...and should refuse to authorize an admission if there are less restrictive community settings in which treatment can be provided.”¹⁵

12 Cmnd. 3703, *Report of the Committee on Local Authority and Allied Personal Social Services* 1968 (Seebohm Report) Appendix F para 273

13 HMSO 1957 *supra*. Q 5392

14 Gostin, L.O 1975 “A Human Condition Vol I” MIND

15 Gostin, 1975 *supra* p. 37

In its evidence, the British Association of Social Workers (BASW) echoed this view, noting that “in law, the social worker’s role has traditionally been regarded as administrative rather than professional; but as its precise limits are not defined, social workers have interpreted it in various ways...we now see the social worker as having an independent role which complements the medical opinions...but this must clearly be seen to be from a basis of professional autonomy...the social worker is usually, nowadays, a comparatively junior member of a large, hierarchical department, and the independent status conferred upon him by law is often difficult to sustain in practice. We support the principle of independence, as a valuable safeguard for the patient, and think that it should be more clearly spelt out in the Act.”¹⁶

In return for this clearly-defined professional role, BASW proposed that there should be mandatory additional training for social workers, and that they should be formally approved under the Act as was already the case for psychiatrists. The government accepted the case for a parallel “social assessment,” and for training and approval, but was unwilling to do more than tinker with the 1959 Act, and so the issue of the social worker’s legal independence was never addressed. In 1983 the MWO’s mantle was duly passed on to the Approved Social Worker, who was required under Section 13(2) to “interview the patient in a suitable manner and to satisfy himself that 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.” This is not dissimilar to the duty of the Justice under the Lunacy Act, who had to “examine the said person and make such inquiries as he thinks advisable...and (be satisfied) that the said person is a lunatic and a proper person to be detained”¹⁷; but the Justice had come, by 1959, to be regarded as a dangerous amateur, who lacked the knowledge to recognise mental illness in all but its grossest forms, whilst the ASW was to be trained to an increasingly high standard.

The government did not, however, accept BASW’s argument that the nearest relative’s power to make an application should be removed, although in the subsequent Code of Practice the ASW became the “preferred applicant.” However, if the ASW did not believe that detention was appropriate, and therefore refused to make an application, the Code nevertheless required him or her to “advise the nearest relative of his or her right to make an application” and to “assist the nearest relative with conveyance to hospital if requested”¹⁸ - thus effectively requiring the ASW to act contrary to his or her professional judgement. Although this situation arises very rarely, it is clear that even in the present law the ASW can still be reduced on occasion to the status of a “mere transporter.”

16 *British Association of Social Workers, 1977 “Mental Health Crisis Services - A New Philosophy.”*

17 *Lunacy Act 1890 Section 16*

18 *Department of Health and Welsh Office 1999 “Code of Practice -Mental Health Act 1983” 3rd edition paras. 2.32, 11.9*

The problems

A more common difficulty in practice, however, is that although Section 13(4) of the 1983 Act places a specific duty on the ASW to visit in response to a request for assessment from the nearest relative, the psychiatrist is under no corresponding legal or contractual obligation to set foot outside the hospital. This had been a problem since 1959, and it was compounded, in 1974, by the transfer of all community health functions from the local authorities to the new health authorities. This allowed the NHS, frustrated by the failure of the new Social Services Departments to build on the sound foundation of the pre-1971 mental welfare services, to set up its own community mental health provision, appointing CPNs alongside the District Nurses and Health Visitors; and, since they could be drawn from a pool of 45,000 hospital staff¹⁹ it was only a matter of time before they outnumbered the social workers and became the dominant force in community mental health.

However, whilst the CPNs stepped into the vacant welfare role of the former MWOs their employing health authorities (now provider Trusts) did *not* inherit the duty to provide a response to emergencies in the community, which remains to this day with the ASWs and with Social Services. It is not surprising, therefore, that “the difficulty in obtaining reliable and speedy attendance of Section 12 (Approved) doctors...is the single issue which is raised most consistently on (Mental Health Act) Commission visits”²⁰ since the Trusts have a very limited interest in resolving the problem. Their responsibility begins only when the patient arrives at the hospital, and to deploy psychiatrists into the community to deal with emergencies would cost them money and reduce the medical cover available to the wards and out-patients, so the ASW still has to rely on persuading a psychiatrist to do an extra-contractual “domiciliary visit,” for a fee and usually in the evening. For the same reason, CPNs in joint community teams, in contrast to their ASW colleagues, have no duty to respond to emergencies other than those involving clients already known to them.

The Expert Committee concludes that “whilst the cause of this problem is complex, its lack of resolution is unacceptable and it must not become a feature of the implementation of new legislation. We recommend that a clear duty be imposed on health authorities.....”²¹ It also recommends that people with mental health problems, including those unknown to services, should have the right to a specialist assessment of their mental health needs via their GP, but it is delightfully vague as to how this should be achieved, suggesting only that “it would be necessary for the Code of Practice to supply the details of how the scheme might work.”²² In reality, unless the duties of provider Trusts are enlarged to include the provision of an emergency assessment service in the community, using both psychiatrists *and* CPNs there is a danger that it may “work” by means of the GPs requesting ASWs to fulfil their obligations under Section 13(4), even in cases where compulsory admission is not an issue.

ASWs are also becoming increasingly anxious, on two fronts, about the question of legal independence. Until 1983 the possibility of being sued was entirely theoretical, since there had been no successful action against an MWO/DAO/Relieving Officer since 1890 and the protection of what is now Section 139 was thought to be watertight; however, that was before Legal Aid was extended to Tribunal hearings and a new breed of specialist lawyers began to proliferate. ASWs

19 Cmnd. 6233 “Better Services for the Mentally-Ill” 1975 Chapter 9

20 Mental Health Act Commission, Eighth Biennial Report 1997-99, para. 4.31

21 Department of Health 1999, *supra*. para 5.16

22 *Ibid.* para. 3.23

now feel very vulnerable, not least because, unlike the doctors employed by the NHS Trusts, they have no contractual indemnity but must rely on the goodwill of their employers if they get into trouble; and in its initial evidence to the Expert Committee, the Association of Directors of Social Services called for a “properly informed debate” on the issue as to whether they should continue to be personally liable, given their “unique position” within Social Services. However, it would be impossible, if they were to revert to the normal legal status of local government officers, for them to perform the duties currently laid on them by the Act, since they would be acting purely “on behalf of the Director of Social Services” and could not therefore exercise the necessary personal judgement.

However, even if the ASWs retain their personal liability, the extent of their independence vis-à-vis the psychiatrist and the receiving hospital, and the need for such independence, is now being brought into question.

The official performing the present ASW role has not always been independent of the hospital - from 1929-1948 the hospital staff and the Relieving Officers were both employed by the local authority - but under the Lunacy Act a hospital doctor could not sign a certificate for admission. However, under both the Lunacy Act and the 1959 Act, doctors employed by the Poor Law Union or in the Health Department will frequently have written certificates or recommendations for their Relieving Officer/DAO/MWO colleagues, and this was not seen as problematic even when - as would have been the case after 1948 - there was an hierarchical relationship between them; but this was, of course, seen as a relationship of officer and sergeant rather than of two autonomous professionals, and in a context where the independent scrutiny of medical judgements was provided not by the DAO but by the Justice.

By 1959 the standing of the medical profession was so high that virtually no-one saw any further need for that scrutiny, and Dr. Broughton, was a lone voice when he protested in the House of Commons that “power for compulsory detention... is given by the Bill to the medical profession. I maintain that it is the duty of doctors to report and to make recommendations. I hold the opinion strongly that doctors are not qualified to take over administrative functions of such gravity as taking away a person’s freedom and restricting civil rights.”²³ However, within the next 16 years the anti-psychiatry movement had undermined much of that standing, and in 1983 the government accepted MIND’s and BASW’s argument that, in the absence of any judicial scrutiny, the exercise of medical power should at least be moderated by an independent social work assessment.

At that time the legal independence of social worker from doctor was not seriously in question, as they worked for completely separate organisations which were sometimes barely on speaking terms with one another. However, successive governments have rightly refused to tolerate such separateness in what should be a “joined-up” service, and recent years have seen the rapid spread of joint mental health services in which the NHS and Social Services “provider” staff are brought under a single management line, and the prospect, encouraged by the Health Act 1999, of a complete fusion of services in many places; indeed, the NHS Plan now makes it clear that where such arrangements are not arrived at by local agreement, they will be imposed by the creation of “Care Trusts.”²⁴ Given the balance of forces, most such mergers will result in ASWs albeit

23 Hansard, House of Commons Vol 598, Mental Health Bill, 3rd reading 6.5.59 p.418

24 Department of Health, 2000 The NHS Plan para. 7.11

retaining their local government employment contracts, being supervised on a day-to-day basis by nurses who are themselves accountable to the managers of the hospital and its medical staff. There is no legal barrier to such an arrangement and, although it is being resisted in some places on professional grounds,²⁵ it seems certain to become the norm rather than the exception.

The way forward

In order to determine the future of the ASW role in the new legislation it will first be necessary to disentangle the several strands of that role which have become entwined over the last two centuries. The oldest of these strands is that of “crisis manager”, which goes right back to 1808 - the responsibility for getting the doctors and other participants to the scene and transporting the patient to hospital. This role, albeit rather more than Lord Percy’s “mere transporter,” requires no independence and is not intrinsically different to the management of a non-statutory mental health crisis, and it should therefore be brought within the normal arrangements for meeting urgent mental health needs, with a responsibility being placed equally on Social Services and the NHS Trusts to provide an emergency assessment service in the community.

The second strand is that of “social assessor” which, although always implicit, has been formally expressed in the legislation only since 1983. It is less easy, 17 years on, to sustain Gostin’s argument that a social work assessment is a necessary counterbalance to a narrow medical view, since the present generation of psychiatrists is far more conscious of the importance of social and environmental factors; and nor is it now safe to assert that ASWs have a greater understanding of these factors than CPNs especially where they work together in joint teams. Rather than defend an exclusive role for the ASW it would perhaps be better to apply to statutory assessments the same principle which is now applied throughout the mental health services, that major decisions should not be taken by a single professional without prior consultation with other disciplines. This principle is already enshrined in the present Act, in the provisions in Part IV (Consent to Treatment) for consultation by second opinion doctors, and in Sections 25 A-J (After-Care Under Supervision), and would in practice require the psychiatrist to seek the view of at least one non-psychiatrist colleague, preferably one who has knowledge of or an involvement in the case.

The third strand is the most controversial, since it concerns the question as to whether it is necessary to have an independent check on the exercise of medical judgement in order to prevent unlawful or oppressive action; and, if so, whether the ASW is the right person to exercise it. Such a check was seen in 1890 as being very necessary, but not at all in 1959, and the enhancement of the social worker’s role in 1983 was not intended to revive the role of the Justice, but merely to broaden the scope of the assessment process. In practice, however, they do tend to portray themselves as the guardians of the patient’s liberties, and as they have received training in the law, and the psychiatrists until very recently received none, it is accepted that they have the primary responsibility to ensure the legal and procedural correctness of an admission. However, this is essentially an administrative function, and one which is shared with the Mental Health Act Officer who scrutinises the documents at the receiving hospital, and it does not of itself elevate the ASW to a quasi-judicial role.

25 Anderson, S. “Viewpoint”, *Community Care* 1-7 June 2000

Nor can ASWs claim to be disinterested parties, which is an essential element of any such role. The detention process is still “founded on the medical recommendations” and the ASW cannot make his or her application until these have been completed, thus giving the appearance that the doctors are the initiators of the process; however, the opposite is frequently the case. Most ASWs are nowadays full-time mental health specialists, acting as care co-ordinators under the Care Programme Approach and as after-care supervisors under the provisions of Section 25; indeed, this is desirable in order to maintain competence in the “social assessment” role and to meet the criteria for continued approval. As a front-line practitioner, with a responsibility for the protection of others as well as the patient, the ASW will frequently be the first to recognise the need for compulsory action and may well be the main advocate for it; for instance, a recent independent inquiry noted how an ASW had protested strongly to a psychiatrist at his refusal to detain a patient whom she considered to be dangerous.²⁶

It could therefore be argued that an ASW is just as likely as a psychiatrist to apply the law in an oppressive manner, and that the main safeguard against this is that the ASW and the psychiatrist act as a check on each other; but this then raises the possibility of collusion or undue influence. There has long been a debate within social work as to whether an ASW who is a close colleague of the psychiatrist will be more, or less, effective in a “civil rights” role than an ASW from outside the multi-disciplinary team, a debate which first surfaced in 1974 when the hospital-based PSWs were transferred to local authority employment and therefore became eligible for appointment as MWOs.²⁷ Many authorities were initially reluctant to appoint them as such, on the grounds that they had traditionally been subservient to the psychiatrists within the hospital hierarchy and that, in Gostin’s words, “the doctor’s status and authority may lead him to exercise an undue influence on the social worker’s decisions.”²⁸

However, the PSWs successfully persuaded BASW to support their case for appointment, on the grounds that their expertise, plus the respect in which they (in stark contrast to their generic colleagues) were held by the psychiatrists, enabled them to exercise a constructive influence behind the scenes which would in practice be more effective than outright confrontation. Doubts persisted, however, and in its evidence to the review of the 1959 Act BASW recommended that a doctor and a social worker who were part of the same multi-disciplinary team should be prohibited from acting jointly, as was already the case with two doctors who worked together.²⁹

With the passage of time, the grounds for concern about “undue influence” have diminished - the present generation of psychiatrists is less authoritarian, and the ASWs are better-trained and more confident. However, as a consequence, the dangers of collusion have greatly increased, as the ideological differences between the two professions have narrowed and multi-disciplinary decision-making has become the norm rather than the exception. In many cases, psychiatrist and ASW will have a close and mutually-dependent working relationship, in a joint service where they share common management, and in such a situation it is difficult to see the ASW as being, in the terms adopted by a recent White Paper of the Council of Europe, a “relevant independent

26 Wigan and Bolton Health Authority, May 2000, Report of the Independent Inquiry into the Care and Treatment of Garry Lythgoe p.19

27 “Detention In Your Own Hospital” Social Work Today Vol 5 No 5 30.5.74

28 Gostin, 1975, *supra*. p. 37

29 BASW, 1977 *supra*. para 21.4

authority confirming involuntary placement or treatment” whose independence “could be verified by the fact that it was a different authority than the one which proposed the measure and by the fact that its decision was a sovereign decision not influenced by instructions from any source whatsoever.”³⁰

This then raises the question as to whether such an “independent authority” would in fact be needed at the initial stage under new legislation in which the final decision on compulsion would be taken by a Tribunal. The Expert Committee, in its original proposals, suggested that in view of its recommendation that there should be a Tribunal hearing after seven days, “it may be less important to demand independence” of the ASW vis-a-vis the doctor.³¹ However, the subsequent Green Paper casts doubt on the practicability of this timescale, opening the possibility that the admission might not be confirmed by a Tribunal until 14 days or even longer (and which would mean in practice that a high proportion of admissions would not be confirmed at all, since the patient would by then have been discharged or made informal.) This is surely too long a period, and would not meet the requirement for timeliness in the Council of Europe White Paper, which envisages that compulsion should be confirmed immediately other than in “an emergency situation.”³²

This points to the need to recast the present role in an explicitly quasi-judicial form. The present training, and the statutory duty set out in Section 13 of the present Act, are not inappropriate to this - what is needed is a greater degree of demonstrable independence and detachment, firstly from the psychiatrist and secondly from the body or bodies providing the treatment and care. In order to ensure the former it might be sufficient simply to enact BASW’s 1977 recommendation that the ASW and psychiatrist must come from different multi-disciplinary teams, but this would not meet the second requirement in jointly-managed services or “Care Trusts”; the most practicable way of achieving this would be to make the ASW in respect of his or her statutory role, accountable to an external body which is not a service provider. The obvious candidates for this would be either the Mental Health Act Commission or its successor body, or the local Health Authorities or Commissions. In the latter case, it would be feasible in the new arrangements under the Health Act 1999 to make the ASW service a jointly-commissioned service, thus retaining the local government connection.

This would in turn make it easier both to contemplate the extension of the role to CPNs and to resolve the question of personal liability. Although there are questions about the appropriateness of their training and experience, the strongest case against the inclusion of CPNs at present is that as Trust employees there is not even a nominal separation between them, the psychiatrists and the hospital, and that their terms of employment require them to follow medical instructions on clinical matters.

In respect of personal liability, it seems clear that the nature of the judgements required, and the fact that they must be made “on the spot,” without reference to management, is incompatible with corporate responsibility. Health Authorities, however, have much less difficulty than does local government with the issue of employees exercising personal judgement and having personal

30 Council of Europe DIR/JUR (2000)2 White Paper on the Protection of Human Rights and Dignity of People Suffering From Mental Disorder p.7

31 Dept. of Health April 1999, Draft Outline Proposals by Scoping Study Committee - Review of Mental Health Act 1983 para 61

32 Council of Europe, *supra*. p.8

liability, and it should be relatively easy within such a framework to give ASWs or their successors both the status and the degree of indemnity which would be necessary for them to act in a quasi-judicial capacity.

Whatever the final outcome, it is essential that the role of the ASW or of any successor should be properly thought-through and redefined in a way which is both clear and internally consistent. The present role, designed originally for an autonomous Poor Law official in the days of chains and madhouses, is an amalgam of legal, professional, administrative and practical functions which have accumulated on a largely *ad hoc* basis over two centuries, and which do not sit comfortably on the shoulders of a modern social worker in a present-day mental health service.