DETENTION, DIVERSION AND DISSENT: MENTAL HEALTH OFFICERS AND THE MENTAL HEALTH (SCOTLAND) ACT 1984

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Introduction

In recent years social workers have gained wider legal powers requiring them to intervene in crises, in the interests of the welfare of individuals and their families.These interventions have often provoked controversy, placing the profession more than ever in the public eye. Whereas there has been a public outcry in Scotland over the manner of intervention by social workers working with children in Orkney, for example, the public have expressed fewer concerns about the potential abuse of power when adults are deprived of their liberty.

The main focus of this paper is an analysis of the role of social workers who act as Mental Health Officers, (MHOs) in the process of compulsory detention of mentally disordered persons under the terms of the Mental Health (Scotland) Act 1984. This is increasingly an area of interest to all who are users of services. Since the implementation of the legislation seven years ago, questions of individual rights, the accountability of professionals, and clarity of roles have come to the fore. For social workers, their managers, policy makers and others concerned with the interests and well-being of people with mental health problems there is a need to know how these procedures operate in day to day practice. Until recently, very little evidence was available to suggest whether procedures were carried out in accordance with either the letter or the spirit of the legislation in Scotland.(1)

This paper focuses on the extent to which the legislation directs or influences how the MHOs carry out their technical and administrative duties within a statutory context; and on how their practice contrasts with that of their counterparts in England and Wales (Approved Social Workers, or ASWs) as regulated by the English and Welsh 1983 Mental Health Act.

The main point that the paper makes is that the MHOs' role can be understood in terms of their particular contribution to assessment and decision-making in the process of detention of mentally disordered individuals. The MHOs' role is shaped by the legislation which defines their powers and obligations, their position in administrative structures, and the relationships with other professionals.

Law and practice

From the point of view of the social work profession, the main development which occurred as a result of the 1984 Act was the incorporation of new responsibilities for social workers. Using specialist knowledge of crisis work and the impact of acute mental illness, together with skills in the assessment of risk, they were to be involved in applications for compulsory detention. Under the 1984 Act (Section 9) local authorities were empowered to appoint "persons" as MHOs to carry out certain circumscribed duties of an administrative, professional and legal nature. It was a requirement that these qualified social workers have at least 2 years experience of mental health work before embarking on specialist training (currently 60 days).

Description of the MHO's role "in law" and "in practice" must be considered together. This paper is premised on a view that the law shapes but does not fully determine practice and that practice is informed by interpretation of the law, not simply its mechanical implementation. Legislation is directed at legal "persons", but professionals like MHOs participate in the process of detention on the basis of their interpretation of the law as they seek the "most appropriate outcome" for a particular person in a particular set of circumstances.

The legislation does not set out the detail required for either professional or organisational purposes. Circulars and Notes of Guidance clarify the need for distinctive social work input to the decision making process.

In making his or her assessment, the MHO has to take account of two elements – the *person being assessed* and the *social context*, including the availability of institutional provision for care of the mentally ill. Assessment of these two elements is at the heart of the MHO's role.

The person being assessed

Those affected by this legislation include people suffering from mental illness, dementia and people with a mental handicap. At different stages in their lives and under different circumstances, people coming from all sectors of the population may be affected by mental illness. It is estimated that 6 million people suffer from mental illness in the UK in the course of a year.[2] Depending on the severity and course of the illness, stabilisation and improvements can occur, especially if medical and social supports are mobilised appropriately. Developments in medical care mean that people may be cared for in community settings if support is available from family and friends and/or social work and health care and voluntary services. The relevant services may include day care, respite care, sheltered or supported housing, counselling and advice.

While 90% of mental-illness hospital in-patients are admitted and accept

treatment voluntarily, the proportion of patients whose lives are directly affected by detention procedures has remained static over the last four decades at 10%.[3] In 1980 there were 11,530 males and 14,322 females admitted to psychiatric hospital while in 1989 the numbers had increased to 13,259 and 15,943 respectively. In 1980, 9.7% of all male admissions and 9.3% of female admissions were formal (compulsory) admissions. By 1989, 9% of male admissions and 7.8% of female admissions were formal.[4]

The social context

MHOs act with the person's welfare in mind. However, they are specifically concerned to judge what is the best place for a person in crisis to receive treatment for mental disorder in the least restrictive way.[5] It is incumbent on both the ASW and the MHO to establish whether detention in hospital is the most appropriate way for that person to receive treatment. This is obviously contingent upon availability of alternative provision. The notion of "alternatives" implies the necessity of taking account of the broad context of provision of care for the mentally disordered. The MHO's intention to find for the person the best treatment in the "least restrictive environment" reflects a concern with the person's welfare and civil rights. It will be seen that legal and organisational contexts influence how those concerns inform practice.

Compulsory powers: definition of roles and responsibilities

The legislation determines the procedures which MHOs ought to follow. However, it must be noted that the law has an "open texture"[6] and does not fully determine practice. Rather, practice is mediated by MHOs' interpretation of the law.

The Act defines the parties involved in the process of detention, including the main professional participants: the authorised officer appointed by the local authority (the MHO); the Sheriff; the psychiatrist (Responsible Medical Officer, or RMO) and other doctors; hospital managers; the nurse; the police officer. The Nearest Relative[7] is also carefully defined and has particular powers in the admission and appeal processes.

The Notes of Guidance on the Mental Health (Scotland) Act (1984) governing admission procedures set out criteria giving psychiatrists the power to define those who require compulsory treatment.[8] Both professionals and patients are regulated by these procedures. When voluntary treatment is not accepted and when other criteria are met, compulsory treatment is provided with the caveat that the rights of patients have to be considered.

The criteria for compulsory admission of a person as defined under section 17 (Mental Health (Scotland) Act 1984)[9] are that:

a) he is suffering from mental disorder of a nature or a degree

> which makes it appropriate for him to receive medical treatment in hospital; and
> b) it is necessary for the health or safety of that person or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this part of this Act.

The main admission and detention sections of the 1984 Act which are referred to in this paper and which can illustrate the nature of the MHO role are section 24 (for emergency admission, and lasting up to 72 hours), section 26 (for short term detention and lasting up to 28 days) and section 18 (for admission and lasting up to 6 months).

Mental disorder is defined as "mental illness or mental handicap however caused or manifested".[10] Mental illness is not defined. While the Act outlines the parameters for decision making, the identification of someone as mentally ill and in need of detention is made by a medical doctor working on the basis of clinical judgement.

Placing issues of detention in context

The involuntary detention of people in psychiatric hospitals has been a contentious issue throughout this century, and in recent decades public scrutiny of these processes has been demanded of the health authorities.[11] To understand the tension in the MHO's role, between concern for the welfare and civil liberties of the person subject to detention, and the need to protect the individual and others, it is necessary to take into account the resource, organisational, political and administrative contexts in which MHOs work.

Resource context

The MHO's assessment and decision making about detention take place against a background shaped by historical, economic and social factors. Specialist knowledge of hospital and alternative provision is an important part of the MHO's assessment when compulsory detention is being considered.

Decisions on where a person is to be cared for are based in part on what facilities are available outside hospital. Scotland and England and Wales differ in their options for care in and outwith hospital. Provision for the care of mentally ill people in hospital is greater and community provision is less in Scotland than in England and Wales. Scotland has historically had a tradition of placing more people in institutions, of having more beds per head of the population for people with mental illness and mental handicap.[12] The Scottish policymakers have tended to favour institutional care rather than rely on community provision. It has been argued that this legacy of high capital and revenue expenditure on hospitals for many years has prevented the transition to a coherently planned programme of community care. The proportion of

people being admitted to hospital throughout the 1980's remained at a high level and the proportion of long-stay patients continued to rise.[13][14]

While a greater proportion of resources are put into Scottish hospitals than into the equivalent service in England and Wales, quantity of service should not be equated with quality of service.[15]

The Scottish Health Service Planning Council Report (1988) underlined the point made by the House of Commons Social Services Committee, that services for mentally ill people continue to be in-patient based.[16] It is estimated that of all the resources spent on mental illness services, 90% is spent on hospital-based provision, the remainder being spent on community services. This is despite the fact that 90% of people experiencing mental health problems live outwith institutions, at home, in hostels, or with relatives. The Mental Health Foundation has stated that in 1989 £636 million was spent to care for nearly 6 million people suffering from mental illness resident outside hospital, while £1,575 million was allocated to the 60,000 in-patients in the UK, equivalent to 71% of all treatment and care expenditure on the mentally ill.[17] Spending on the NHS and on social work services has increased but it cannot be assumed that this means that provision overall is better. Nor does the high provision of hospital beds automatically imply a more appropriate service for people with mental illness.

It is important not to assume that the Mental Health Acts of 1983 and 1984 are concerned with setting up alternative community care schemes or that MHOs (and ASWs) are duty bound to facilitate these. The Eleventh Report of the House of Commons Social Services Committee (1990)[18] emphasises this point in stating:

> the aim of community care as set out in the White Paper is to provide services to enable people to live as normal a life as possible in their own homes or in a homely environment in the local community: community care is not aimed at people who are acutely ill.

Thus, social workers do not dogmatically pursue diversion from hospital treatment. Concern with meeting individuals' needs could often imply treatment in hospital in an acute phase of illness. For the majority of people, hospital may be the appropriate place for treatment. When discharge is imminent, local authorities have a duty, under section 8, to 'provide after-care services for any persons who are or have been suffering from mental disorder'. After-care, rather than care in an acute phase of illness, is the point at which community care should be considered if such resources are in place.[19]

Organisational context

Social work services in Scotland are planned centrally but administered at

Regional level through Social Work Departments. All local authority social workers are guided by legislative procedures but are accountable to the Director and the appropriate Social Work Committee. Some Acts are applied throughout Britain and others apply only within Scotland (eg The Social Work (Scotland) Act 1968, and the Mental Health (Scotland) Act 1984 fall into the latter category).

MHOs' authority to carry out their role in detention derives from their position in the Social Work Department. However, unlike the social work role where they act as agency representatives, as MHOs they are empowered to act semi-autonomously.[20] The duties of the MHO are considered

> a natural extension of their functions as social workers, but it should be noted that there is a distinction between the functions of a local authority which may be delegated to and carried out by a social worker, and the functions of a mental health officer which that same social worker, if duly appointed, carries out as a specified officer and which are not delegated functions.[21]

They are said to act in their new role as assessors, advocates and negotiators.[22]

There is variation in practice between MHOs in the scope given to them by managers in Social Work Departments to exercise their role and in the levels of community and alternative resources available to use.[23]

However, despite the differences in the organisation of social work services between the Scottish and the English and Welsh systems, it should not be assumed that social work practice is significantly different since the training for social work is governed by the Central Council for Education and Training in Social Work[24], a body with a UK-wide remit, and social workers (including MHOs and ASWs) share a common base in social work education.[25]

Political and administrative context

A discussion about the timing and the content of the respective Acts will illustrate how the Scottish legislation is different from that in England and Wales, and how those differences affect the context in which practitioners in the two systems work.

The Scottish Acts of 1960 and 1984 stood in the same relation to the parallel English 1959 and 1983 Acts, in that the Scottish Acts followed the general reforming pattern in the UK. There was a similar urgency to obtain reform in Northern Ireland.[26]

The way that the Scottish Bill was passed and the decision not to fund the implementation of the Bill from central sources shaped the MHOs' role. There

was concern at the time that the passage of the Scottish legislation may have been too hasty.[27] In effect, the 1983 Mental Health Act was more extensively debated, both because legislation affecting the large majority of the UK population takes precedence and because the Scottish debate was curtailed because of the calling of an election in 1983.

Implementation of the law requires adequate funding of new services, training and personnel. The duties imposed on local authorities had a number of resource implications and this led to much debate at the time both within Parliament and within and between professional organisations. Training of new and existing staff was essential at the outset. The absence of new funding was a major drawback to the implementation of both Acts and occasioned more concern than did disputes within the social work profession and between health and social work professions over changes in duties required by the Act.[28]

Participation in the process of detention

Given the different organisational structure, how do MHOs and ASWs manage their participation in the processes of detention in order to provide independent assessments of risk? This question is important in considering how MHOs and ASWs may, by virtue of their common training in social work, share common ideologies and yet, because of differences in the contexts in which they practice, enact roles which diverge in terms of civil rights and welfare ideologies.

Differences between the MHO and ASW roles will be discussed under the following headings:

a) assessment
b) timing of entry into the detention process
c) differences in role and power
d) Nearest Relative role
e) interprofessional relationships

a) *Assessment*

MHOs' and ASWs' participation in the process of detention can be understood in terms of assessment. The nature of the assessment they carry out may be similar but it may have a different impact on detention because it is done at a different point in the process and because it may have a different weight in relation to the opinions of other professionals (ie psychiatrists and Sheriffs).

In both the Scottish and the English and Welsh legislation, changes were instituted to ensure that, where possible, people should be treated voluntarily; and that detention would be used only when necessary and, for the mentally

disordered, only if the condition was treatable. These changes were made with the rights of patients in mind.

The professional training of the MHO and ASW would enable her or him to carry out an assessment[29] taking account of:

1) the balance of risk factors to the individual or others;
2) whether hospital is the best place for the person to be detained given the person's vulnerability and current state of mental health;
3) the gravity of withdrawing anyone's rights and liberty, even for a short period.

1) Sheppard[30] has formulated a framework to describe the social context of the ASW's assessment in terms of a 'risk' model. This is in contrast with the medical practitioner's use of the classic 'medical' model to assess the necessity for treatment and detention. This analysis can be applied to the work of the MHO, as it centres on social work assessment skills.

2) These designated officers look both at the circumstances of the person, to assess the possibility of risk to self or others, and at whether hospital is the best place to provide treatment assuming the grounds of mental disorder are met. This involves examining and using knowledge of alternatives (treatment in the community), whether of a voluntary, statutory, private or charitable nature. Sheppard describes how ASWs act as 'gatekeepers' investigating the possibility of alternative resources. Sheppard[31] cites Barnes et al[32] and Fisher et al[33] and states:

> recent research suggests that this 'diversion' of patients away from compulsory admission was to a considerable degree the result of ASW intervention. This reflected a philosophy of adopting the 'least restrictive alternative'. Diversion effected out of hours showed more reliance on family and social work resources, while other formal medical and psychiatric resources were used during normal working hours.

This illustrates one way in which the ASW can both protect a person's civil liberties by diverting someone away from compulsory detention and also protect their right to treatment.

3) The Mental Health Act itself is procedural and to some extent it can define and legislate for professional practice in certain circumstances. In relation to applications for short-term and longer detention, the legislation states that the MHO should interview the patient, provide the Responsible Medical Officer and the Mental Welfare Commission with a report on the patient's social circumstances and inform the Nearest Relative about the proposed detention.

The MHO must interview the person in a suitable manner so that the

person's views can be elicited and his or her rights explained. The General Practitioner and relatives would also be consulted to give their views on the person's usual state; and the relatives too would be apprised of their rights. There is a number of formal implications to consider when assessing whether someone's liberty is to be restricted including the limitation on future employment opportunities, and of rights to enter other countries. Similarly, the informal implications including the effect on close relationships and on self-esteem, and the possibility of a admission/re-admission patient "career", are important factors to take into consideration.

b) *Timing of entry into the detention process*

The timing of entry of the MHO and the ASW into the process of detention differs. The English and Welsh legislation defined the ASW's principal remit as that of an applicant for a formal order. By contrast, unless invited by the medical practitioner, neither the relative nor the MHO may contribute to the process of detention at the emergency stage. The MHO's role is, as consequence of later entry into the process, more reactive. This means that MHOs have less authority in the process than do ASWs.

c) *Differences in role and power*

In terms of a clear role and the protection of civil rights, there are some similarities between the roles of the MHO and the ASW.[34] Within the Scottish system the MHO has a minimal role in counterbalancing the medical view to protect rights early in the process. ASWs are able to refuse to apply on behalf of the person, while the MHO is obliged to put a recommendation to the Sheriff for a longer period of detention if requested to by the RMO. This implies that MHOs are not involved in diverting people from compulsory detention status either to voluntary status or to an alternative resource outside hospital. Recent evidence shows that MHOs are indirectly involved in diversion.[35] However this may be far more the outcome of informal working practices, since the legislation does not authorise the practice of diversion in the MHO role.

In Scotland, MHOs are seen as giving consent to the recommendation for emergency admission or short term detention. If the MHO disagrees with the admission, he or she may "withhold consent". However, the detention can go ahead but only if the relative agrees.

d) *Nearest Relative role*

The wider role of the ASW or MHO may be considered in terms of their place in the process of detention including when and how they take part and their role in relation to the Nearest Relative, the psychiatrist and the Sheriff.

Over time, a role has developed for a non-medical officer – such as a social

worker – in the process of detention. It has been a longstanding tradition in Scotland for the Nearest Relative, rather than a professional, to perform the function of application for detention.[36] Indeed, the Nearest Relative is referred to before the MHO in the Act. In the case of an emergency admission, any relative (or MHO) may give consent to the admission; in the case of the other admission sections, the Nearest Relative (or MHO) may give consent. The Nearest Relative also has rights of discharge.

The MHO's role might be seen as a development of the administrative role of the Poor Law relieving officer, a more independent, non-medical duly-authorised person who would make the application to admit the person to hospital, but only where the relative was not available.

At one level, the MHO can be viewed as standing in place of the relative, acting to support and confirm the medical decision to detain the individual compulsorily.[37] In the majority of cases it is the MHO who carries out the application. The Report of the Mental Welfare Commission for Scotland 1989[38] states that MHOs applied for section 19 admission in 94% of cases, an increase of 4% over the 1988 period.[39]

e) *Interprofessional relationships*

The MHO's power to act on professional judgement is lessened quite directly because there is no obligation on the part of the psychiatrist (or GP) to invite the MHO to assess the person.[40] Commonly, the first involvement may be when an MHO is called to assess someone already in hospital or to write a social circumstances report (SCR) once the person is in hospital.

The Code of Practice for the 1983 England and Wales Act stated that it is good practice for an ASW to be involved in every assessment as the "preferred applicant".[41] The ASW's professional semi-autonomous role is complementary to the medical role. The English and Welsh legislation permits the ASW to have a view which differs from the medical view and which carries professional authority. The legislation establishes the basis for the social perspective, as expressed in the ASW's assessment, to come into play to prevent what the ASW considers an unnecessary hospital admission.

The 1983 legislation in England and Wales incorporated the view that the definition of someone warranting compulsory admission for the treatment of mental disorder was the responsibility of the psychiatrists. In Scotland, by contrast, compulsory admissions to hospitals are processed with the additional confirmation of the judiciary in the person of the Sheriff. This approach was displaced some 40 years ago in England and Wales.[42]

Differing perceptions of the person and implications for detention

This discussion of assessment has emphasised the perspective that MHOs

bring to decision-making about detention. The notion of "perspective" implies different positions from which the person liable to detention may be seen; for example, as an object of intervention intended to promote the person's welfare, or to defend his or her civil liberties. It has been argued that, though the law "frames" the person, it is professionals who must see a particular person in his or her circumstances in order to act in the process of detention. The professionals "see" in terms of perspectives and ideologies acquired during their training. These professional perspectives – for example, of social workers and medical practitioners – may or may not coincide. Even within social work, there may be both common and divergent perspectives.

Often, the professionals involved share a view that detention in hospital is the best possible place for the person. The outcome then is that the person remains in hospital for the length of the section period; or until such time as the Responsible Medical Officer dispenses with the section. In the meantime, the individual has a right, under sections other than the emergency order, to appeal to the Mental Welfare Commission, the hospital managers and the Sheriff. Although there are these mechanisms for appeal once the patient is in hospital, the time that it takes to involve a Sheriff may militate against a proper exercise of rights, as by this time the patient's mental state may have stabilised, in which case a 'section' is no longer applicable and may be withdrawn by the Responsible Medical Officer.

Tibbitt[43] conducted a study focusing specifically on the MHO's role in Scotland under the 1960 legislation. He found that there was variation in practice; and that there were difficulties in the exercise of the duties, leading to tensions, particularly in relation to working collaboratively with others and within the administrative and legal framework. Tibbitt[44] showed that the MHO may bring to the situation of possible or actual detention a view different from that of the medical practitioner. This is, of course, entirely appropriate. If the MHO's judgement entails disagreement with the medical view, as happens when the MHO witholds "consent", then this could affect interdisciplinary working adversely. Whether actions are perceived as legitimate depends on the extent of mutual understanding.[45]

Concern with welfare and civil rights

In assessment, MHOs draw on ideologies formed in training. Mental Health Officer training develops skills of assessment and advocacy, psychiatric knowledge, and community knowledge. The persons's mental state is not the sole focus of the MHO's assessment. The MHO's role is neither to determine the existence of mental disorder, nor to enter into a debate about the existence of mental disorder. Sometimes MHOs may only become involved after detention has taken place, as in the case of the 28 day section, when they must write a report on the patient's social circumstances for the Mental Welfare Commission and the Responsible Medical Officer.[46] This appears to be in contrast to the practice of ASWs in England and Wales who, being involved at

the start, can divert people from compulsory detention.[47]

The Scottish Act could be seen as institutionalising a concern with protecting civil liberties by specifying the Sheriff's role in the detention process. This role is to confirm and approve applications and to hear appeals. The professional role of the MHO is limited, as the Sheriff is there to resolve

> any conflict of opinion between medical practitioners who believe that the patient ought to be detained in hospital and the mental health officer who thinks otherwise.[48]

This reflects the power inherent in the two other professionals' position in relation to the MHO and has more in common with the position in England and Wales before 1959.[49]

Appeals

The roles of MHOs and ASWs also differ in relation to participation in the appeals process. In England and Wales the patient (and in certain circumstances, the Nearest Relative) may appeal to hospital managers and/or to a Mental Health Review Tribunal (usually comprising three people representing medical, social and legal perspectives). The Mental Health Review Tribunal can come to hospital and speak with the person, the ASW and the psychiatrist informally. Formal legal representation is not usually requested. In Scotland, cases of detention are reviewed by the RMO after four weeks; the individual may at any time notify the Mental Welfare Commission to request that his or her case be reviewed; and the hospital managers, the Nearest Relative, and the Responsible Medical Officer, may discharge patients.

The appeals process in Scotland, where a Sheriff is involved, is more daunting than in England and Wales, perhaps involving the individual's having to attend a hearing in the more formal court setting. Furthermore, Sheriffs are typically generalists, hearing cases on mental health in the same way as cases about housing, for example. They do not necessarily specialise in mental health in the way their counterparts may under a Tribunal appeals system. Sheriffs take into account the views of professional experts in deciding on appeals (ie the RMO and the MHO). The system is also underpinned by the notion of the independence of the judiciary, each case being looked at individually and independently according to the same procedure, whereas under a Tribunal system mental health cases would be examined similarly. Finally, the outcome of each case is based on the judgement of the individual Sheriff, without reference to a core of decisions in similar cases. This means that there is scope for wide variation in Sheriffs' practice across Scotland.

Conclusion

The legislation lays down a minimum basis for the protection of the liberty of individuals and of society in relation to specific detention sections. Within that structure, there is a certain amount of flexibility for MHOs to develop and refine good practice. This discretion has been facilitated by new arrangements embodied in the 1984 Act. This Act is by no means unproblematic. Arguably, the legislation could be improved by allowing the MHO earlier entry into the assessment process.

While the Scottish Act of 1984 introduced a more developed social assessment role for MHOs, the reliance on the judicial process fundamentally limits the range and scope of their interventions. While this may be appropriate, it means that the role is far less clear for MHOs in Scotland than for the analogous workers in England and Wales. It would be simplistic to think in terms of a dichotomy – ASWs seen as civil liberty orientated and MHOs as welfare orientated. It would appear on the surface that MHOs are operating on the basis of a civil rights perspective more than a welfare perspective. However, in Scotland, protection of the person's civil liberties depends not on the MHO alone, but ultimately on the judgement of the Sheriff, based on his or her experience in handling applications and reliance on expert psychiatric opinion.

It is suggested here that the ASW's practice would more clearly include civil liberties aspects because, among other reasons, they have the power to divert compulsory admission if they disagree with the RMO's recommendation (in the short term, before the Nearest Relative decides to apply).[50] Anderson-Ford and Halsey[51] suggest that the 1983 Act in England and Wales is more civil libertarian than the 1959 Act, since the ASW's role is designed to balance the medical role. Sheppard supports this view, but as noted above argues that, in order to achieve this balance of power in practice, ASWs need to adopt a "social risk" orientation rather than a "mental health" orientation. This would be in keeping with social work practices in child care.

Both ASWs and MHOs work in systems characterised by a tension between providing care and treatment as necessary, and restricting liberties in the interests of others or for the good of the person. MHOs' power to limit civil liberties is less than ASWs' power. MHOs cannot directly divert persons away from detention even if alternative resources are in place.

Even taking into account differences in practice discussed above, MHOs and ASWs share a common role in asserting the importance of social factors in the consideration of someone experiencing a mental health crisis.[52] Both possess powers delegated through the respective Mental Health Acts to address the particular crisis or social problem. This paper has emphasised the "open texture" of the law.[53] MHOs and ASWs (as well as the other professionals involved in detention) have the discretion to interpret procedures and codes and make professional decisions about whether a particular individual in the particular circumstances is to be admitted.

Knowledge of the letter of the law is insufficient for understanding the complexity of MHOs' practice.[54] That knowledge must be supplemented by knowledge of the organisational and interprofessional and social contexts within which decisions on detention are made.

While the focus of this paper has been on the MHOs, it is vital to maintain awareness of the "missing perspective". The views of the person subject to assessment for detention and of his or her relatives have been little researched. An interesting point to consider is whether the different administrative procedures mean that an individual's experience of detention is radically different north and south of the border. Further development of good practice could possibly lead to the detention experience being less traumatic for the individual and the family.

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References

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   The National Mental Health Monitoring Study in Scotland 1989-90 (Smith, 1991) involved monitoring the implementation of the Mental Health (Scotland) Act 1984. Data were collected on all the statutory actions undertaken by MHOs in 1989-90. This quantitative study replicated the earlier monitoring exercise in England and Wales (Fisher and Barnes, 1987). Smith (1991) provided data on the total number of MHOs operating throughout Scotland (405), where they were based, and the frequency, scale and scope of their work. The majority (67%) were based in psychiatric hospitals, 20% in area teams and 10% in emergency duty or out of hours teams. The remainder (3%) were based in health centres or other atypical bases. Smith (1991, p 79) examined a range of variables and highlighted the large amount of regional variation in practice.
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15. It should not be assumed that everyone experiencing mental illness is located and provided for in hospital or in the community, as it is known that the prison population includes people with mental health problems.
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17. Thompson D and Pudney M (1990), *op cit*.
18. House of Commons Social Services Committee (1990) *Community Care: Services for People with a Mental Handicap and People with Mental Illness*, HMSO.
19. Department of Health and Social Security (1975) *Better Services for the Mentally Ill*, HMSO, London. The emphasis on community care to some extent reflects a re-appraisal of attitudes and responses to the notion and experience of 'mental illness'. There has also been a shift in the language used in official documents over the last decade from 'the mentally ill' and 'the mentally disordered' to 'people with mental health problems'.
20. As well as facing the possibility of being sued for wrongful detention, another implication of this role is that they may be involved in acting against Regional policy by acting as an advocate and pressing for resources.
21. Scottish Home and Health Department (1984), *op cit*, p.22.
22. Social Work Services Group (1983) *Appointment of Mental Health Officers under the Mental Health (Amendment, Scotland) Act 1983: Working Party Report, July 1983.*
23. Smith, R (1991) *op cit*. The 1990 National Mental Health Monitoring Study in Scotland (p 78) highlighted some of the regional variation in work undertaken by MHOs. Between 3 to 33 per 100,000 of the population were assessed for section 24 (emergency); between 11 to 39 per 100,000 for section 26 (short-term). There was also a seasonal variation, in that referrals in May were high and those in April low. On average, MHOs were asked to consider the use of statutory powers over eight times in the year, although social workers based in psychiatric hospitals carried out most of the work across all Regions.
24. Central Council for Education and Training in Social Work (1989) *Requirements and Regulations for the Diploma in Social Work Paper 30*, CCETSW, London.
25. Central Council for Education and Training in Social Work (1989), *ibid*. Training and education is now co-ordinated by local consortia partnerships of statutory and voluntary employing authorities and higher education, central government and CCETSW representatives. However, CCETSW will continue to have a central function and will ensure common standards.

26. The legislation in Northern Ireland was implemented 2 years later.*Mental Health (Northern Ireland) Order 1986*, HMSO, Belfast. 27. House of Commons Scottish Grand Committee *Mental Health (Amendment) Bill (Lords) (1983) Second Sitting, 10th March*. HMSO.
27. One Scottish MP, Martin O'Neill, MP for Clackmannan and East Stirlingshire, commented at the time of the Scottish Amendment Bill debates: "It is regrettable that the Government here sought...to rush through the legislation. The consultative period was limited and we only conclude that the Bill was produced because there was one in England and the Government wanted to ensure that Scotland would have similar legislation with the names changed to suit Scottish circumstances. We would have preferred a longer period for consultation".
28. The Scottish Office would argue that there was central funding allocated since the local authority rate support grant was 'topped up' to cover the changes, and that the responsibility for using this money lay with individual authorities.
29. Such assessments are often of people not known to the MHO, and may have to be carried out quickly, in complex circumstances, with limited information.
30. Sheppard M (1990), *op cit*.
31. Sheppard M (1990), *ibid*, p.5.
32. Barnes M, Bowl R and Fisher M (1986) 'The Mental Health Act 1983 and Social Services', *Research Policy and Planning*, 4, pp1-7.
33. Fisher M, Barnes M and Bowl R (1987) 'Monitoring the Mental Health Act 1983: Implications for Policy and Practice', *Research, Policy and Planning*, 5, pp1-7.
34. Brown, R (1987) 'Social Work and Mental Health Teams: The Local Authority Field Social Worker', in Taylor R and Ford J (eds) *Social Work and Health Care Research Highlights in Social Work* No.19. Jessica Kingsley, London.
35. Smith R (1991) *A Study of Mental Health Officer Work in Scotland: National Mental Health Monitoring Study in Scotland 1989-90*, University of Stirling.
36. McGregor C (1985) 'Mental Health Officers and the Scottish Acts of 1960 and 1984', in Horobin G (ed) *Responding to Mental Illness: Research Highlights in Social Work No.11*, Kogan Page, University of Aberdeen.
37. McGregor C (1985), *op cit*.
38. *Report of the Mental Welfare Commission for Scotland 1989*, (1990) HMSO, Edinburgh.
39. Set up under *The Mental Health (Scotland) Act 1960*, under the Scottish Act in 1984, the Mental Welfare Commission was given wider powers to hear appeals from detained individuals and to discharge patients. They may be viewed as a counterbalance to professional power in decision-making. The Commission receives copies of all documents related to detention. They exercise a function of protecting people who are mentaly disordered, having a duty to ensure that no patient is detained improperly.
40. However the Mental Welfare Commission examines all cases where consent to detention has not been obtained and failure to do so is only acceptaable on the ground of 'impractability' *(Report of the Mental Welfare Commission 1989, 1990 p.36)*. However, 480 out of 3,271 emergency detentions in 1990 were made without the consent of any relative or a MHO *(Report of the Mental Welfare Commission for Scotland 1990, 1991)*.
41. Department of Health (1990) *Code of Practice: Mental Health Act (1983)*, HMSO, London.
42. Bean P (1987) 'The Mental Health Act (1983): an Overview', in Brenton, M and Ungerson C (eds) (1987) *The Yearbook of Social Policy 1986-7*, Longman, London.
43. Tibbitt (1978) *Social Workers as Mental Health Officers*, HMSO, Edinburgh.
44. Tibbitt (1978), *op cit*, p.38.

45. McGregor C (1985), *op cit*.
46. Scottish Home and Health Department (1990) *Code of Practice Mental Health (Scotland) Act 1984*, para 1.12, HMSO, Edinburgh.
47. Barnes M, Bowl R and Fisher M (1990) *Sectioned: Social Services and the 1983 Mental Health Act*, Routledge, London.
48. Scottish Home and Health Department (1984) *op cit*, para 38 p.30.
49. Currently, lawyers in England and Wales only become involved after detention, ie at the Mental Health Review Tribunal.
50. See the Government Circular in *The Code of Practice for England and Wales* (Department of Health, 1990), drawing attention to the Nearest Relative's right to make application. However, the Mental Health Commission in 1985 *First Biennial Report*, reported that 90% of admissions were carried out by ASWs.
51. Anderson-Ford D and Halsey M (1984) *Mental Health Law and Practice for Social Workers*, Butterworth, London.
52. Brown R (1987) *op cit*, pg.59.
53. Sheppard M (1990), *op cit*.
54. Bean P (1986) *Mental Disorder and Legal Control*, Cambridge University Press. Bean's criticisms of social work practice have not taken into account some of the issues raised in this paper regarding the complexity of the relationship between law and practice.