

Decision-Making in Mental Health Law: Can Past Experience Predict Future Practice?

Jill Peay¹

Introduction

The short answer to this is no. Whilst it may be possible to be certain about the occurrence of some events, the prediction of decision-making requires caution and qualification. Yet past practice can be a good guide to making informed guesses about the future. Accordingly, this article addresses the question of whether what we know about how practitioners make decisions in respect of current mental health law can help us to understand how the government's latest proposals for reforming mental health law are likely to fare. Two main issues are discussed: first, the nature of the proposed criteria; and second, the nature of the process, who will get involved with whom? The article concludes with some miscellaneous observations and engages in some autopoietically inspired kite-flying.

Before embarking on this a few words of warning are necessary. Nothing that follows is rocket science (or as rocket scientists say, quantum physics).² It is based on what practitioners have said honestly and frankly about their own problems in applying the current legislation. And the problems that they have encountered are not exceptional. It is commonplace for many of our decisions to be based on fear, uncertainty and occasionally, frank ignorance. Moreover, lawyers are not an exception to the rule. As Lady Hale has observed 'lawyers might be clearer about the legal principles involved, but they would still be torn about how to fit the perceived needs of the individual case into the prescribed legal framework'.³ Finally, what people say they do, and say they have done, is not always wholly consistent with their practice. In this context, predicting what they will do is hazardous.

1 Dr. Jill Peay, Reader in Law, London School of Economics. This article was presented first to the 2nd North East Mental Health Law Conference organised by Northumbria University Law School and Eversheds (solicitors) in November 2004. I am grateful for the comments I received then and latterly to my colleagues Richard Nobles and David Schiff. Any misunderstandings that remain of the relevance of autopoietic theory are entirely of my own making

2 Perkins, E. (2002), *Decision-Making in Mental*

Health Review Tribunals London: Policy Studies Institute; Peay, J. (1981), 'Mental Health Review Tribunals: Just or Efficacious Safeguards?' *Law and Human Behavior* 5, 2/3, 161–186; Peay, J. (1989), *Tribunals on Trial: A Study of Decision Making Under the Mental Health Act 1983*. Oxford: Oxford University Press; Bryson B. (2003) *A Short History of Nearly Everything* London: Random House

3 In Peay, J. (2003) *Decisions and Dilemmas: Working with Mental Health Law* Oxford: Hart Publishing at page v.

The Draft Mental Health Bill 2004 underwent detailed examination by the Joint Scrutiny Committee (JSC).⁴ Their report was published in March 2005. This article is based on the proposals as set out in the Bill as it was first published in September 2004. There are a number of features in this that I welcome. This is not surprising since these features stem largely from the recommendations of the Richardson Committee: for example, the single gateway to compulsory power, early intervention by an independent decision-making body – the Tribunal – to approve an agreed care plan, arrangements for advocacy and the nominated person proposals. There are some features about which I am agnostic, being in support in principle but anxious about their practical application; for example, the need for independent decision-making by doctors and an approved mental health professional before compulsory assessment can take place with those decisions being independently justified. However, I am anxious that these potentially welcome developments are likely to be obviated by the practical application of the new Bill, since this will, in my view, extend the boundaries of compulsion in a way that makes many aspects of the proposed legislation unworkable. And then there are numerous features of the Bill that I find problematic. These include consigning the limited and non-obligatory principles to the Code of Practice (which will prove an unreliable sign-post for non-legal practitioners); new criteria for admission and treatment which are broader in scope than even the existing criteria (which will act as a lobster pot in drawing people into compulsion but making it conversely harder to escape from the pot of compulsion); the use of compulsion in new settings (outside of hospital and without the natural restraint of the requirement for a hospital bed); the introduction of more explicit obligations on professionals (see, for example, clause 60) whilst reducing existing discretion (see, for example, the absence of an overarching discretion on the tribunal to discharge in any circumstances); the need only to *consult and involve* patients and nominated persons in decision-making; reliance on language which is subjective ‘appropriate treatment must be available’ and value driven, relying on such terms as ‘warrant’, ‘expedient’ and ‘necessary’; and a Bill that runs to 307 clauses, 14 schedules, an application which may be modified geographically (note, as ever, the Isles of Scilly in 307(7)) and details as yet to be specified in Regulations and the Code of Practice. In short, a non-lawyer’s nightmare and a lawyer’s paradise.⁵ The government has quaintly asserted that only people who need compulsion will be subject to it (that is, compulsion won’t be used unnecessarily). It is not clear on what basis this assertion is made.

Many of these problematic features arguably derive from the fundamental approach adopted by the government, since it has chosen to justify the use of compulsion on grounds of necessity. In so doing it has rejected the Richardson Committee’s approach, which was based on the principles of autonomy and non-discrimination; an approach that would have resulted in some form of, albeit attenuated, capacity based legislation.⁶ However, as Rosie Winterton has stated in defending the government’s necessity based approach

4 The proceedings of the Joint Scrutiny Committee (JSC) on the Mental Health Bill can be found at: http://www.parliament.uk/parliamentary_committees/jc_dmhb.cfm

5 The introduction of conspicuously unclear and complex legislation that requires extensive judicial clarification has attracted criticism before. In January 2005 Lord Justice Rose, Vice President of the Court of Appeal’s Criminal Division, observed that bringing the provisions of the Criminal Justice Act 2003 into force

before appropriate training could be given obliged the Court of Appeal to engage in ‘unsatisfactory activity, wasteful of scarce resources in public money and judicial time’. See J.Rozenberg ‘Judge condemns new jury ruling’ news.telegraph filed 15th January 2005.

6 G. Richardson (1999) Review of the Mental Health Act 1983. Report of the Expert Committee, Presented to the Parliamentary Under Secretary of State for Health 15 July 1999, published November 1999 by the Department of Health.

'we have concluded that existing mental health legislation relies on the only practicable basis for compulsion to prevent harm. Whilst a capacity based system may suffice to protect people from unnecessary intrusion, it is ineffective to prevent the harm to themselves or others which may result from their disorder.'⁷

1. The Proposed Criteria and their Likely Application

The government has proposed in Clause 9 of the Draft Mental Health Bill 2004 that the following conditions should apply to the use of compulsion

9 The relevant conditions

(1) *In this Part, references to the relevant conditions are to the following conditions (subject to subsection (7)).*

(2) *The first condition is that the patient is suffering from mental disorder.*

(3) *The second condition is that that mental disorder is of such a nature or degree as to warrant the provision of medical treatment to him.*

(4) *The third condition is that it is necessary –*

(a) for the protection of the patient from –

(i) suicide or serious self-harm, or

(ii) serious neglect by him of his health or safety, or

(b) for the protection of other persons,

that medical treatment be provided to the patient.

(5) *The fourth condition is that medical treatment cannot lawfully be provided to the patient without him being subject to the provisions of this Part.*

(6) *The fifth condition is that medical treatment is available which is appropriate in the patient's case, taking into account the nature or degree of his mental disorder and all the other circumstances of his case.*

(7) *The fourth condition does not apply in the case of a patient aged 16 or over who is at substantial risk of causing serious harm to other persons.*

(8) *For the purposes of this Part, a determination as to whether a patient is at substantial risk of causing serious harm to other persons is to be treated as part of the determination as to whether all of the relevant conditions appear to be or are met in his case.*

A number of these terms will be familiar to those working with the Mental Health Act 1983, and in that context, decision-making under that Act should provide some guide as to the interpretation and application of these terms. I will be drawing for my observations and limited predictions mainly on *Decisions and Dilemmas: Working with Mental Health Law*.⁸ This research involved 106 mental health practitioners, made up of s.12(2) approved psychiatrists, second opinion appointed doctors (SOADs) and approved social workers (ASWs), who variously took part in three decision-

⁷ Memorandum from Rosie Winterton, Minister of State, Department of Health (2004) *Mental Health Bill – Necessity vs Capacity* submitted to the JSC (DMH 396) and available on the JSC web site

(above). See also the responses to that memorandum by Richardson (DMH 408) and Peay (DMH 407) on the same site.

⁸ See Peay 2003 above

making exercises. These required the practitioners to make decisions individually and as part of a pair on the basis of extensive written and video-materials. Here is not the place to defend the methodology, but it does enable me to make some observations about how non-lawyers perceive, apply and justify their use of mental health law in respect of one of three decisions: to admit a patient under compulsion, to discharge a patient or to give treatment without consent.

So, how are these criteria likely to be applied?

Do notions of uncertain risk promote use of compulsory powers?

The most striking aspect of the criteria is that they are imbued with notions of risk; this is not surprising given the government's form on this issue.⁹ The criteria will require practitioners to assess whether action is necessary to prevent the future occurrence of harm; practitioners will have further to make a prediction as to the level of harm that is thought likely to occur. Whilst self-harm requires a high threshold to be passed (suicide or serious self-harm), harm to others is couched in the most general language 'the protection of others'. No indication is given as to the degree of probability of this harm occurring. However, it is logical to infer that the degree of probability is something less than a 'substantial risk', since clause 9(7) makes explicit reference to a substantial risk when serious harm to others is entailed. Thus, 'the protection of others' in clause 9(4)(b) may draw in any degree of physical, psychological or financial harm, or arguably even mere perturbation to the well-being of others. Whilst it is hard enough to weigh known facts, weighing the future is impossibly difficult. In those circumstances where mental health professionals are currently required to make predictions about uncertain risk, their thinking and their decisions were imbued with caution: thus,

we are trying to make predictions in situations of uncertainty and in a sense we are bound to err on the side of safety. In some ways it's the only error we are permitted to make because we are expected to protect individuals, and we are expected to protect the public. This is part of our overall responsibility and if the balance is tipping towards increasing concerns, I don't think we can put it aside.....not to do something and wait to find out, well, we might find out what we don't want to find out **ASW, pair 17**

In some ways I feel that the law gives you that little bit more support. Say he goes on a s.3, it does tighten everything up. I don't think it's so bad to use the law and I'm not saying I don't think twice about it. There are times when I have put people on a section and I've thought gosh I'm depriving that person of their liberty. It's not something that you can take lightly. I think that I do use best interests all round. I think now, almost all of us are so fearful to let things slip, it's almost like you are saying it's in the best interests for me as well because if this goes horribly wrong then I cop for it. I am the scapegoat. **ASW, pair 22**

Interacting with one another, different kinds of uncertainty about the law, the possibility of future harm and the obligation to protect 'others', combined to produce a situation that was potentially full of dread; resort to the law provided a kind of prop. And whilst the law was not fully

⁹ See the government's Draft Mental Health Bill 2002; and the preceding White Paper, Department of Health and Home Office (2000) *Reforming the Mental Health Act Part I: The New Legal Framework Cm 5016-1; Part II: High Risk Patients Cm 501-II London: The Stationery Office Ltd; and the Green Paper, Department of Health (1999) Reform of the Mental Health Act 1983. Proposals for Consultation. Cm 4480 London: The Stationery Office Ltd; and commentary thereon, Peay, J. (2000), 'Reform of the Mental Health Act 1983: Squandering an Opportunity?', *Journal of Mental Health Law* 5-15.*

understood, it was sufficiently familiar to provide some element of comfort. In cases of doubt therefore, there was an incentive to resort to the use of law. By introducing greater uncertainty and lower thresholds for action in the face of risk, the Draft Bill looks likely to be used more, not less, than the current Act.

The use of informal admission – avoiding the Act

Whilst there is an incentive to use the Act in cases of uncertainty, another theme that can be seen in the decision-making of practitioners was to avoid using the 1983 Act where a desired result could be achieved informally. It is hard to predict quite where the resolution of the problem posed by Bournwood patients (the compliant but incapacitous patient) will ultimately fall,¹⁰ but historically the bulk of these patients have not been admitted under section. The research findings illustrated the thinking that sometimes lay behind these decisions: pair 37 would have taken the patient, Mr Draper, into hospital informally where he assented to admission, informally for a ‘rest’, informally even if he was very deluded (although here the psychiatrist would have wanted to section) and would have accommodated coerced informal admission, that is in circumstances where they knew that his consent to admission was given in order to avoid being taken into hospital under section. Thus,

if he is willing to hold his hand out and say I'll come in for a rest, then it would achieve most of my objectives, at least in terms of keeping him safe and keeping his neighbours safe and I would be prepared to settle for that in the first instance, knowing full well that if he changes his mind, after whatever length of time it takes us to make our assessment, to take a decision about what we want to do in treatment terms. The options are still open to us at that stage to do something ... **ASW, pair 37**

This approach is not uncommon, and is supported by the statistics on the use of coercion in hospital; that is, of patients who enter hospital either by consent or informally, who subsequently find themselves subject to section. To illustrate, in 2002–3 there were 25,112 compulsory admissions under Part II of the 1983 Act and 18,611 conversions of voluntary/informal patients to compulsory status in hospital.¹¹ In short 43% of the uses of compulsion under Part II occurred with patients already in hospital. And, as Bindman and his colleagues have suggested, the use compulsory sections *in hospital* may take place more readily where staff have acquired a sense of responsibility for patients as a result of their prior voluntary/informal admission.¹²

Of course, not all practitioners responded in the same way to a patient showing clear signs of incapacity in the context of compliance. For some, the ethical dilemmas involved were acknowledged:

I don't think it is satisfactory... It is not very fair on the in-patient nursing staff either, because you are really just transferring the responsibility of making the decision to them. **Psychiatrist, pair 26**

10 The government clearly needs to address the breaches of Article 5 set out by the European Court of Human Rights in *HL v UK* October 2004, but they have seemed uncertain as to whether the remedy is best addressed under a new Mental Health Act or under the new Mental Capacity Act; see, for example, Department of Health (2005) *Interface between the Draft Mental Health Bill and the Mental Capacity Bill (DMH 405)* available on the JSC web site above.

11 Department of Health (2003) *Statistical Bulletin: In-patients formally detained in hospitals under the Mental Health Act 1983 and other legislation 2002–03*. London: Department of Health and National Statistics, Statistics Division 2.

12 J. Bindman, Y. Reid, G. Thornicroft, G. Szmukler and J. Tiller (2001) *A Study of Experiences of Hospital Admission*. London: Report of a Study Commissioned by the Department of Health Research and Development Division

This psychiatrist would also have used the compulsory provisions for admission where the patient's agreement to admission occurred after some mention of the 1983 Act

otherwise he is not really coming in informally, he is coming in under duress.

Others were more influenced by resources issues. For example, the ASW in pair 35, who used informal admission liberally, observed:

If you have a view of the mental health services as excellent services then those who can be persuaded will be persuaded and those who can't because they are deluded can come in informally anyway. I'm not certain in what context you'd want to use the Mental Health Act because the safeguards become almost redundant if you have a very positive view of mental health services. ASW, pair 35

Where a practitioner's view of mental health services is not so positive, resort to compulsion may be more likely. As the Rethink Report has questioned, is it the inadequacy of community mental health services or the bleakness and squalor of acute wards that makes voluntary admission less likely and compulsion more likely.¹³ What cannot be denied is that there has been an increase in the use of compulsion of nearly 30% in the last decade.¹⁴ Again, it is not clear how clause 9(5) will be interpreted (*that medical treatment cannot lawfully be provided to the patient without him being subject to the provisions of this Part*) in the context of a pre-existing Mental Capacity Act that provides for lawful medical treatment of those lacking capacity, even if some use of restraint is entailed.

Complex criteria – conflating the issues

Another issue concerns how practitioners use complex legal criteria, criteria that may need to be independently satisfied. That non-legal practitioners may use the law in novel ways, ways not anticipated by the legislature, was evident from the research. Thus, the phenomenon of conflation across all of the criteria for admission could be seen.

I've got three parameters here. I've got nature or degree and I've got risk and any one of them can add points onto the score to take me up to my threshold. There has got to be a bit of illness, but if the risks are getting higher, the risks of me not engaging with this man and leaving it are becoming unacceptable. I then have to decide right, if this man is not safe out there where does he need to be? Does he need to be in hospital or does he need to be in custody? ... If he's not ill then it would be the police. If I am a bit more towards ill then I'd probably go for hospital. With history, I'd go for illness, just because of his history ... because the Act is couched in such non-specific terms, isn't it? That's all we can do. It does have the potential to be misused. Psychiatrist, pair 14

Yet even this 'graphic equaliser' approach would suggest that for some practitioners a pure form of preventive detention (that is, in the absence of illness) would not be acceptable. How practitioners will respond to the proposal under Clause 9(7) that patients with a mental disorder of a nature or degree warranting medical treatment who are at substantial risk of causing serious harm to other persons *cannot* be treated on a voluntary basis is not clear.

13 Rethink (2004:7) *Behind Closed Doors: Acute Mental Health Care in the UK* London: Rethink

14 See Department of Health 2003 above

A pragmatic approach?

Of course, some risks are more pressing than others. And not all risk is related to some underlying abnormality. What should happen where a potential patient has no history of offending, but is making threats? Where the risk is one that is merely predicted, practitioners recognised that there was greater difficulty. As one ASW put it:

I think you'd have to look at that very carefully, because people make threats to other people and indeed carry them out and it has absolutely nothing to do with them being mentally ill. So, is this an issue perhaps for the police if he is making those kinds of threats under the influence of drinking...or is this about somebody who is relapsing into a psychotic illness and acting under some kind of delusion or hallucination in some way? ASW, pair 14

The research study illustrates well how, through experience, decision-makers tend to learn the rules of the game and make their decisions in the light of all of the factors that they might be required to consider. Constraining themselves to use only those that legitimately apply to the particular facts of a given case was more problematic.

Will the new tribunal make a difference?

Another reason why some practitioners used the current Act was because it provided patients with a formal safeguard against the abuse of compulsion. To some, this was a comfort.

I don't feel comfortable about section 3 being renewed, but, it may be what we need to do, so that he has got some rights while he is in hospital to call a tribunal which he wouldn't have as an informal patient. It also gives us powers if we do find somewhere that he can go on leave, but we can recall him as and when necessary. ASW, pair 17

However, it is self-evident that if the new Tribunal is to have no discretionary power to discharge and will apply the same broad criteria used to justify assessment and treatment, then there is little prospect of it acting to remedy the inappropriate use of compulsion, for there will be little bite in the criteria it is obliged to apply. On the other hand, this situation may not be so different from that as currently envisaged by some practitioners, who clearly took the view that tribunals are as 'realistic' in their application of the law as were practitioners. Difficult choices resulted in pragmatic solutions by all concerned.

Hopefully, it's morally defensible. Yes, I must say that in my experience I think the tribunal will probably uphold, whether or not they are right in doing it in law I don't know, but I think they probably use the same line of reasoning as us – this is a chap who is a pretty serious risk and he needs to be closely supervised – and perhaps one would hope that they might not be so strict about the rigid letter of the law. I don't know. Psychiatrist, pair 35

For some who took part in the research the conflict between their ethics and a pragmatic solution was all too apparent, but this conflict could be resolved by adopting a cautious approach (when considering renewal of a section).

I think ethically the more justifiable thing would be not to renew it and to say the problem is one of resources, not one which can be solved with the use of the Mental Health Act. I've been at a tribunal where a patient of mine was discharged on the basis that the tribunal felt she could be managed at home safely providing there was a community psychiatric nurse visiting twice a day over a period of two or three weeks. We endeavoured to do this in that individual case by withdrawing resources from other

clients, so in the end it was an economic decision which probably is possible in theory. Taking each case in isolation so you could manage a lot of people at home if you could put in sufficient resources. But if you can't, then the safest option is to detain. ... I might be inclined to renew with misgivings.

Psychiatrist, pair 36

Will compulsory community treatment be over-used?

Moving patients seamlessly from compulsion in hospital to compulsion in the community is likely to prove attractive to those practitioners who are understandably cautious about tolerating risk. There was evidence from the research that practitioners were fully prepared to renew a section solely in order to ensure that a patient could be moved from hospital into some community setting on s.17 leave where medication could still be administered under compulsion and the patient could be returned to hospital if matters deteriorated (or the practitioner's ability to tolerate risk changed).¹⁵ Thus:

It seems a shame that one is having to renew a section 3 just to allow a period of leave of absence down the line. But given his history, I think there will be a risk if he went out without any legal structure around him. Also, I think he is getting restless and very frustrated, although he is not trying to abscond at this point in time. Once he realises he could leave, I am not sure that he would stay and he may make his way to his sister's and cause problems there. **Psychiatrist, pair 17**

Practitioners' perceptions that they had no other option are also evident in their use of the terminology of constraint.

It's difficult to place people with this sort of history and his combination of needs. So I feel my hands are tied reallyrenewal on a section 3, but I would welcome him appealing against it. It's one of those sections where I feel unhappy about it. **Psychiatrist, pair 17**

This perception can be self-constructed (and indeed, in the research, it was evident that other practitioners given exactly the same factual situation did feel that there were other options). But, the ready availability of community treatment is likely to prove popular amongst some practitioners, at least in the first instance. And once community treatment is in place successfully, the conditions under which it might be deemed unnecessary become even harder to envisage. Hence, patients and clinicians may become trapped in a coercive relationship akin to the current arrangements for conditional discharge for restricted patients.

Use of supervised discharge

Using the law as a coercive tool was not without its ethical difficulties, which were acknowledged by some. Thus, one psychiatrist, who had experience of successfully maintaining three psychotic young men on s.25A in the community, recognised that using supervised discharged raised an ethical dilemma.

I think the trouble with it is the lack of ethics around being completely open with people about what it actually means. To be perfectly honest, this section 25 is a piece of paper and it means nothing You say 'these are the conditions, do you agree to them?' Well they say 'alright then' and I am going to renew it and I have renewed all three of them and it has worked and they have perceived a legal framework, and it is dodgy, I think morally dodgy but in the end, this is an end that justifies the means. They stayed

¹⁵ *R v Barking Havering and Brentwood Community Healthcare NHS Trust [1999] 1 FLR 106, R (on the application of DR) v Mersey Care NHS Trust (2002) Times October 11 2002, and CS v MHRT [2004] EWHC 2958 (Admin)*

out of hospital, they stayed well and they are starting to work and doing all sorts of things.

Psychiatrist, pair 14

However, the dilemma for this psychiatrist was acute for, when challenged about whether he told his patients that medication could not be enforced in the community, he responded:

Yes...and I told them the truth, obviously in a sort of whisper.

Under the Draft Bill's proposals the dilemma is somewhat different. The clear expectation is that compulsion will not be used in a patient's home, but that transport to an appropriate facility will be required. However, when a patient is faced with the choice of transport plus compulsion, or immediate 'compulsion' in the privacy of their own home, how many are likely eventually to concede?

Substantial vs significant: what is the difference?

The Draft Bill employs a great deal of subjective language; uncertainty will necessarily accompany its use. However, there is a further problem; namely, that language of particular significance to lawyers does not necessarily have the same significance to non-lawyers. Thus, the Draft Bill uses the words 'substantial risk of serious harm'. At face value substantial seems to imply more than significant. But to the participants in the research the relationship between these two terms was variable and often obscure.

I think because I'm hesitating. I can't think of a good reason why it's different, I think it probably means the same. **Psychiatrist, pair 40**

Some felt the terms were interchangeable; others rated a substantial risk as low as a 10% chance of the predicted event occurring during the six months period of the s.3; and some as high as 70%. There was, therefore, considerable tolerance in use of terms.

For whose benefit?

There was also evidence that some practitioners were prepared to use the law to protect themselves, by adapting a clinical opinion in order to fit the Act. One has considerable sympathy with a practitioner's preparedness to do this, particularly when confronted by a perceived risk or where it enables a practitioner to pursue what are regarded as actions in the best interests of a patient. Thus:

... pragmatically, if it gets me to the position where I have him on a section 3, then I can work towards the supervised discharge and try him out in a hostel. I would rather be in that position, than let him go.

Psychiatrist, pair 35

But what lay behind this was only occasionally revealed. For in one case there was an honest admission that this strategy of manipulating the 1983 Act was not in order to achieve the objective the psychiatrist had earlier claimed, namely to prevent the patient from relapsing and returning to Broadmoor Special Hospital, but rather:

It's really there for our protection, I think. I think the Mental Health Act is there for the protection of patients, but it is very obviously there for the protection of medical practitioners as well. I admit that. I think that your personal experience exposes you to the crucifixion of other doctors; there was a major incident where they allowed a schizophrenic chap to go home, he stabbed his sister-in-law to death, two years ago. It made the front page of the Yorkshire press. As a result, you can feel them breathing down your neck. It does change your view. **Psychiatrist, pair 35**

Self-protective strategies were evident in the thinking of other practitioners. For example, in pair 30 the ASW argued for s.25A and wanted to place the patient, Mr Wright, on the local supervision register; the psychiatrist revealed that nothing could convince her that Mr Wright was 'safe' and so she wished to use renewal under the Act as a form of desensitization for herself. As she stated

He hasn't had a structured pattern of leave or been integrated into the community with supervised leaves. And just to expect him to go straight from the hospital to the community...it's really nerve wracking. In fact, I wouldn't do it. **Psychiatrist, pair 30**

On being confident that you have reached the right clinical decision?

The SOAD in pair 6 was concerned that there was no way of being certain whether other SOADs would agree with the proposed course of action.

Just like most consultants act autonomously, where you don't really know what your colleagues are doing, likewise with SOADs. SOADs act by themselves. We get together for training days and we might let off steam about how difficult it is to arrange second opinions and all sorts of mechanics but I don't know if we actually discuss ethics..... we're asked to give an opinion on somebody else's treatment plan and there has to be a line between what is acceptable and what is unacceptable. **SOAD, pair 6**

The Draft Bill proposes establishing new expert panels. Quite how these will operate is not clear. Indeed, will there be training for them together with all of that necessary for the new tribunal members? How are standards to be achieved? How are expert panel members to feel supported in their decision-making?

Or the right legal decision?

Whilst the Draft Mental Health Bill 2004 makes no reference to advance directives, the Mental Capacity Bill 2004 does. It is therefore entirely possible that practitioners will have to deal with complex situations where advance directives are in place, but their legal effect under the 1983 Act is unclear. Under the current arrangements practitioners have enough problems knowing how to deal with the conflicting views of relatives and a patient about a patient's (non-binding) advance directive. Thus:

the whole thing with this one is a real minefield, but I would want to approach them separately just to check out that she really was competent when she made the advance directive and ask them what they want me to do. I'm afraid these days, more and more you're thinking how is this going to look in court? What is this going to look like at the inquest, if you take the worst-case scenario? What is the coroner going to say, when I say to the coroner 'yes, I let her down'? **SOAD, pair 11**

The desire to share the responsibility for these difficult decisions was evident.

I'm very hesitant on this because I don't know what I would really do. In reality I may well say I would rather have somebody else participate in the decision or take the decision, and say go ahead, do this. **RMO, pair 11**

I believe I ought to respect the advance directive but would find it extremely difficult to do so and I would probably try to park the responsibility with the SOAD. **RMO, pair 13**

To which the SOAD responded:

To be honest with you, I would phone the Mental Health Act Commission and try to chew it over with somebody legal, as I am honestly not sure of the position. **SOAD, pair 13**

All of this implies some confusion about the operation of the current Act, a statute that has been in force for over 20 years. Quite how practitioners will cope with the demands of the new legislation is not clear. The Royal College of Psychiatrists already anticipate that psychiatry will become an even more difficult discipline in which to fill the necessary consultant posts.¹⁶ But what is clear is that to many practitioners the law was a foreign land and certainly an unfamiliar language. But curiously, it largely did not seem to matter. The question that was uppermost in the minds of these practitioners was not whether their decisions were lawful or unlawful, but rather whether they were the right decisions in all the circumstances. And being right might entail right for the patient now, or it might entail right for the practitioner, or it might entail right with a prospective view of hindsight. But all these possibilities would suggest a creative and defensive application of the legal tools available. On the basis of this platform of current knowledge about decision-making, I remain unconvinced of the government's assertion that the use of compulsion would not increase were the Draft Mental Health Bill to be enacted in its current form.

2. The Process: Who Makes Decisions with Whom?

Two issues will be addressed here: those relating to group decision-making and those relating to multi-disciplinary decision-making.

Group decision-making – are two or more heads better than one or just different?

Too many years ago, when I was a PhD student looking at the decision-making of Mental Health Review Tribunal (MHRT) members under the 1959 Mental Health Act, there was much discussion about whether groups made riskier decisions than individuals (this was known as the 'risky-shift' phenomena).¹⁷ However, during my research it became apparent to me that the process was subtler than the name implied; in practice, what seemed to occur was that groups made more extreme decisions than a consensus model of decision-making might suggest. Thus, group decision-making seemed to result in decisions that were either more risky than their individual members would have tolerated or more cautious. And in my research it was evident that the tripartite structure for MHRT decisions was resulting in decisions that were generally more cautious than the individual members would have made had the decision been one for them to make alone.

This phenomenon could also be observed in the *Decisions and Dilemmas* research.¹⁸ For example, in the decision about discharge in the case of Mr Wright, 63% of the 80 psychiatrists and ASWs who looked at the case individually would *not* have renewed his section. But when the decision was then made in pairs, 58% of the pairs ultimately favoured renewal, the more cautious strategy for the management of this case. What had occurred between the individual decision and the paired decisions to bring about this remarkable change of heart? Was it that the individuals favouring renewal always had the more persuasive arguments, or that they were in a position to override anyone favouring not renewing? Intuitively, one would have expected the psychiatrists to have been

16 See, for example, the evidence of the Royal College of Psychiatrists to the JSC (DMH 24 at p.27), and from the Department of Health (DMH 404) Resources and the Regulatory Impact Assessment which notes at paras 20–21 that vacancy rates in 2004 for psychiatrists exceeded those for other medical and dental groups (9.6% compared with 4.3%) and that this differential had increased since 1996.

17 See Peay (1980) *A Study of Individual Approaches to Decision-Making under the Mental Health Act 1959*, unpublished PhD thesis submitted to the Department of Psychology, University of Birmingham and Peay 1981, 1989 above

18 See Peay 2003 above

dominant in this decision, since in law the discretion to renew lies exclusively with the Responsible Medical Officer (RMO). Yet tellingly, in all the 6 cases where the ASW's view prevailed (a counter-intuitive finding) the ASW was arguing for a more cautious strategy than the RMO; and in four of those cases the ASW favoured renewal, where initially the RMO would *not* have renewed. Thus, there was a shift to caution where the decision was made in pairs. What this seemed to imply is that the use of compulsion under the current Act may be facilitated by the method by which decisions are made. Two heads are different than one.

Under the arrangements proposed for the Draft Bill 2004,¹⁹ individual practitioners will have to make the decision as to whether a person should be admitted under compulsion for assessment and then justify those decisions in writing. Three practitioners will be required (in non-emergency situations) to authorise compulsion. If any one practitioner decides against the use of compulsion the process of moving towards assessment under compulsion will be stopped. At first sight, this may imply a welcome pressure against the unnecessary use of compulsion. However, in practice, it is possible that practitioners will quickly gain a reputation in respect of their compulsion-mindedness. And that professionals will find themselves teaming up for assessments with others of a like mind, thereby undermining the structural 'reverse pressure'. Alternatively, if one practitioner ultimately says no to compulsion where two others have already endorsed its use, will the process be re-commenced but with a replacement third party being nominated to undertake the assessment? Whilst this may be an overly cynical assessment, there is evidence from the research (see below) that practitioners are aware of their own and others 'track-records' and moderate their behaviour accordingly. Thus, heads sequentially structured may make a difference, or they may not.

Multi or duo-disciplinary decision-making

A great deal has been written about whether it is possible for different disciplines, such as law and psychiatry, to talk to one another in a meaningful fashion. I do not intend, indeed I am not qualified, to explore the finer points of autopoietic theory here.²⁰ However, an albeit crude analysis of its central tenets does provide an insight into what may be happening when decisions are made in a multi-disciplinary context.

Autopoietic theory propounds that the law (and presumably other disciplines like medicine) is an autonomous system whose operations are self-referential and closed: the law thus deals in specialised communications which have different meanings from those of other closed systems, for example, medicine. Yet, the multi-disciplinary nature of decision-making under mental health law, whether it is by MHRTs (entailing lawyers, doctors and lay people) or by the duo-disciplinary decision-making entailed in the decision to admit a patient to compulsion, is predicated on effective shared communications between different disciplines. Evidence of the ability of different disciplines to communicate effectively with one another is mixed,²¹ but there is some evidence

19 See clauses 15–18

20 M. King and A. Schutz (1994) 'The Ambitious Modesty of Niklas Luhmann' *Journal of Law and Society* 21, 3, 261–87. And for a helpful analysis by G. Teubner, R. Nobles and D. Schiff (2002) 'The Autonomy of Law: An Introduction to Legal Autopoiesis', in J. Penner, D. Schiff and R. Nobles,

Jurisprudence and Legal Theory: Commentary and Materials London: Butterworths.

21 See for example, M. King and C. Piper (1995) *How the Law Thinks About Children* Aldershot: Arena; and R. Nobles and D. Schiff (2004) 'A Story of Miscarriage: Law in the Media' *Journal of Law and Society* 31, 2, 221–224.

from a fascinating observational study of the role of doctors on MHRTs that doctors can and do act in the role of ‘translators’ when moving between clinical and legal issues.²²

Autopoiesis does not state that effective communication can never occur between functionally different worlds. Indeed, the theory provides a more complex understanding of what comes within ‘effective communication’ through the concept of structural coupling. This concept describes a potential process for facilitating relationships between different social domains. The key, as Teubner and his colleagues observe, to successful structural coupling ‘lies in unlocking a hidden agenda toward compatibility between different worlds’;²³ and this in turn entails the ‘processes of “creative misunderstanding”’.²⁴ This concept will be returned to below, but suffice it to say at this stage, it is possible that under current legislation the unstated concept of best interests may fulfil this role, thereby enabling effective communication to occur between doctors and ASWs.

However, another possibility exists; namely, that the true nature of multi-disciplinary decision-making is not multi-disciplinary at all; one discipline, for whatever reason in the particular context, simply trumps. During the research it was evident that on a number of occasions either ASWs or psychiatrists (but usually the former) were prepared to defer to the other professional, seemingly against their better judgement, on the basis of what was perceived to be privileged knowledge.²⁵ Thus, in a number of pairs either the notion of clinical risk or that of risk to others would cause the ASW to defer to a psychiatrist who was promoting a more cautious strategy than the ASW would have preferred (that is either to admit under compulsion to treatment, or to renew a section in the case of a patient who was already detained).

The conventional role of the ASW in the decision to admit a patient has historically been seen as one of potentially acting as a brake on an otherwise overenthusiastic psychiatrist employing a decision-making approach dominated by the medical model; ASWs are thus able to offer a different context for decision-making and, in an ideal world, provide alternatives to mere resort to compulsion in hospital. And there was evidence in the research to support the notion that ASWs could be effective in this role. For, of the 40 paired decisions about whether to admit Mr Draper, 22 were cases where the ASW’s views prevailed, in 9 the psychiatrist prevailed and in 9 the decision was evenly balanced. These numbers are in marked contrast to those in the decision to discharge where exactly the same pairs considered the case of Mr Wright, but here in 22 pairs the psychiatrist dominated the decision outcome, in 6 the ASW prevailed and in the remaining 12 pairs neither party dominated the outcome. The evidence is therefore that where the law favours one discipline over another (and in the decision to admit the compulsion cannot be used unless the ASW is prepared to ‘sign the pink forms’, whereas in the decision to renew, the statutory responsibility falls to the RMO) that party can dominate in the decision-outcome irrespective, arguably, of the persuasive value or legitimacy of their arguments.

As interestingly, it is possible to use the data to look at the influence that individuals have irrespective of their professionally privileged position. This is a topic of some importance where

22 See G. Richardson and R. Machin (2000) ‘Doctors on tribunals: A confusion of roles’ *British Journal of Psychiatry* 176, 110–115 at p114.

23 Teubner et al (2002) above at 914–915

24 *Ibid.* at 915

25 One of the advantages of the research design was that it was possible to look not only at which professional in

each group dominated the decision-making, in the light of knowledge as to their preferred individual strategy, but to look also at whether the law privileged one professional over another in respect of either the decision to admit or the decision to discharge. This would not be possible merely by observing real-life decision-making where individual decisions do not currently have to be pre-stated.

individuals make decisions with or alongside other individuals with whom they already have a decision-making track record. Two matters are of note. First, even over the course of two decisions involving the same pairs of decision-makers it was possible to observe the consequences of a past interaction: some individuals, who had failed to operate effectively in the first paired decision, approached the second in a more measured fashion, whilst others appeared more combative. Independence of mind can be moderated both by the knowledge of past interactions and by the prospect of future ones. Second, some individuals were just more dominant than others. In nine of the pairs one party dominated both decisions irrespective of their statutory role: thus, six psychiatrists and three ASWs were dominant in both the case of admission and of discharge. In 11 pairs the decision-making followed the statutory pattern (that is, the ASW dominated admission; the psychiatrist dominated discharge); in one case, this pattern was reversed, and for the remaining 19 cases there appeared to be reasonable agreement between the pairs. So, in some pairs the law has an influence through its allocation of statutory roles, but in others, individuals trump seemingly regardless of any structure the law might have tried to impose.

All of this leads me to be somewhat cautious in making predictions as to how the new tripartite, but sequential, model for the decision to admit under compulsion for assessment will function. What I feel I can be confident about is that there will be unanticipated perturbations in the process.

3. Miscellaneous (and Concluding) Observations

Decision-avoidance

You don't need to do research to know that there are some decisions that we all try to avoid making and that some people are more indecisive than others. So it is no revelation that there was evidence in the research that some of the paired decision-making was dominated by a seeming desire not to have to make a decision at all: this could entail a hunt for more or better information, a decision to delay taking any further action until some designated future point, or to admit a patient informally on the basis that this deferred the current problem to a different context. On questioning, a number of ASWs who did night-time or week-end rotas also reported a tendency for other practitioners to delay a case until it fell into the purview of the out-of-hours practitioners, in essence passing the buck to them. In respect of the Draft Mental Health Bill 2004, it might be argued that it will be more difficult to engage in these strategies and avoid making decisions since the Bill is generally much more prescriptive than the 1983 Act, requiring explanations of inaction as well as action.²⁶

The new kid on the block

There was also in the research a curious fascination with all things new, as if somehow these might be the solution to long-standing problems. For example, there was considerable discussion of the potential role of s.25a (supervised discharge) in Mr Wright's case (even though he would probably not have satisfied the criteria for this section).²⁷ The notion that supervised discharge could give practitioners some additional control over a patient in the community was attractive. Yet, s.25a is

²⁶ For example, under clause 15(3) where the decision is made to assess the patient in the community, rather than to detain, the practitioner is required to specify the conditions to protect the patient's health or safety or that of others thought to be at risk of harm; and clause

38, where there is a duty on the clinical supervisor to apply to the tribunal where the relevant conditions are met.

²⁷ Introduced in 1995 as an amendment to the Mental Health Act 1983.

arguably a section with few, if any, teeth; treatment cannot be given under compulsion in the community even on this section. Indeed, the section is not dissimilar to the long-standing option of guardianship. Yet that provision was almost never mentioned during the research. Thus, if compulsory treatment in the community is introduced as outlined in the new Draft Bill, it may prove popular partly because of its very newness.²⁸

Context – training and experience

How decisions get made about any individual case will be influenced by a host of factors unrelated to the law: for example, a practitioner's experience and case-load, the resources available, the objectives being pursued by any one practitioner, the climate of opinion, and/or an individual's ability to tolerate risk and uncertainty. One striking example from the research will suffice: of the 40 psychiatrists drawn from across the country who reviewed the case of Mr Draper, 30 of them would have admitted him under compulsion had the decision been one for them to take alone. Of the 20 psychiatrists with a forensic background from the Institute of Psychiatry who reviewed the same case, none of them would have admitted Mr Draper. He was, to them a 'soft case'.²⁹ Similarly ASWs with a large forensic load seemed much more tolerant of potential risk than did newly qualified s.12(2) psychiatrists with no forensic patients. Undoubtedly, the new arrangements under the Draft Bill will both extend responsibilities to new practitioner groups (psychologists if acting as clinical supervisors, and others who qualify as approved mental health professionals) and draw in more practitioners *per se* under the expanding boundaries of compulsion under the Act.³⁰ All of these people will require training.³¹ Maintaining consistency is likely to be problematic, which in itself is unlikely to help address one current and very real concern with the use of the current Act; namely, its inconsistent use and its seeming over use with some ethnic minority groups.³²

Cognitive errors

The study of cognitive errors is a subject in its own right. Again, suffice it here to say that these are relatively enduring features of decision-making that will bedevil any attempt to impose a new regime in decision-making in mental health law with a view to achieving specified objectives. Subjects such as frame constriction, the single option fallacy, over-confidence and ignoring your track record all have a part to play.³³

28 *The Draft Bill does not mention community treatment orders as such since the Bill envisages a seamless transition from treatment in hospital to treatment in the community; however, evidence to the JSC, see above, was replete with discussion of the disadvantages (and advantages) of having a power to treat under compulsion outside hospital.*

29 See Peay 2003 at 159

30 See also J. Peay, C. Roberts, and N. Eastman (2001), 'Legal Knowledge of Mental Health Professionals: Report of a National Survey', *Journal of Mental Health Law* 44–55.

31 See, for example, the submission of the Regional Chairman to the JSC where it is asserted that it would take approximately nine years to complete the interview

processes alone for the appointment of all the necessary new tribunal members (DMH 200 at para 9).

32 See Department of Health (2005) *Delivering race equality in mental health care: an action plan for reform inside and outside services and the Government's response to the Independent inquiry into the death of David Bennett* (Available on the DoH web site: 11th January 2005)

33 See, for example, A. Bartlett and L. Phillips (1999) 'Decision Making and Mental Health Law' in Eastman N and Peay J. (eds) *Law Without Enforcement: Integrating Mental Health and Justice*. Oxford: Hart Publishing; Peay, J. (1999), 'Thinking Horses not Zebras', in Webb, D. and Harris, R. (eds.), *Managing People Nobody Owns* London: Routledge.

Best interests: the autopoietic solution?

Whilst the concept of best interests clearly has a defining role to play in the Mental Capacity Act 2005, its role under the Mental Health Act 1983 is limited and it is much more limited under the Draft Mental Health Bill 2004. Yet, when practitioners were asked how they defined their own roles under the 1983 Act it was clearly a key concept. Coming from a clinical perspective this is entirely understandable. It is also perhaps not so surprising that some ASWs also saw this approach as being more relevant to their work than a legalistic approach or an autonomy-based ethical approach. It would therefore probably be unwise to assume that its practical centrality will be downgraded in terms of the *application* of any new Mental Health Act, particularly in the absence of clear defining principles on the face of the statute; as currently drafted, the 2004 Bill would assign its limited principles to a Code of Practice and then permit those principles to be disapplied, for example, where 'inappropriate or impracticable'.³⁴

Whether clinicians, ASWs and indeed lawyers mean the same thing when they assert that their decisions are based on the principles of 'best interests' is a moot point. However, from the perspective of autopoietic theory, its very malleability and lack of agreed definition may make the concept of 'best interests' hugely useful to facilitating communication. Creatively misunderstanding precisely what is meant when both psychiatrists and ASWs strive to achieve what they (differentially) believe to be in a patient's best interests may facilitate ultimate 'agreement' between these different disciplines involved in the application mental health law. In short, the paternalistic form of best interests arguably provides the invisible mortar that keeps the edifice of the 1983 Act in place. For, if autopoietic theory is correct and one discipline cannot speak meaningfully to another, then having a creative misunderstanding based on a term that has meaning in all three disciplines (psychiatry, social work and law), even if not necessarily the same meaning, may permit the impossibilities of accurate translation to be at least partially obviated.

But autopoietic theory also provides an avenue to think about how such creative misunderstandings can lead to newly invented opportunities for co-ordinated action.³⁵ If practitioners are prepared to adhere to a self-defining regime that may not wholly reflect what is on the face of a statute, it is possible that as mental health becomes increasingly to be seen as on a par with physical health, that practitioners will reach for a newly invented understanding of best interests. This version of best interests, already present in the Mental Capacity Act 2005 in a nascent form, may be one that requires clinicians to respect what a patient determines is in their interests, where that patient retains capacity.³⁶ Thus, autonomy-based best interests rather than paternalism-based best interests may serve to ameliorate what might otherwise be the less attractive features of the proposed new legislation. If so, then multi-disciplinary decision-making based on a creative misunderstanding may revive the justification for a several-headed approach to mental health law.

34 Clause 1(4)(a)

36 See S.4

35 See Teubner at al 2002 above at 915