Mental Health Act reform

Emerging challenges

DAVID PILGRIM *and* **DAVID HEWITT** *discuss the practical and legal implications of the proposed 'clinical supervisor' role.*

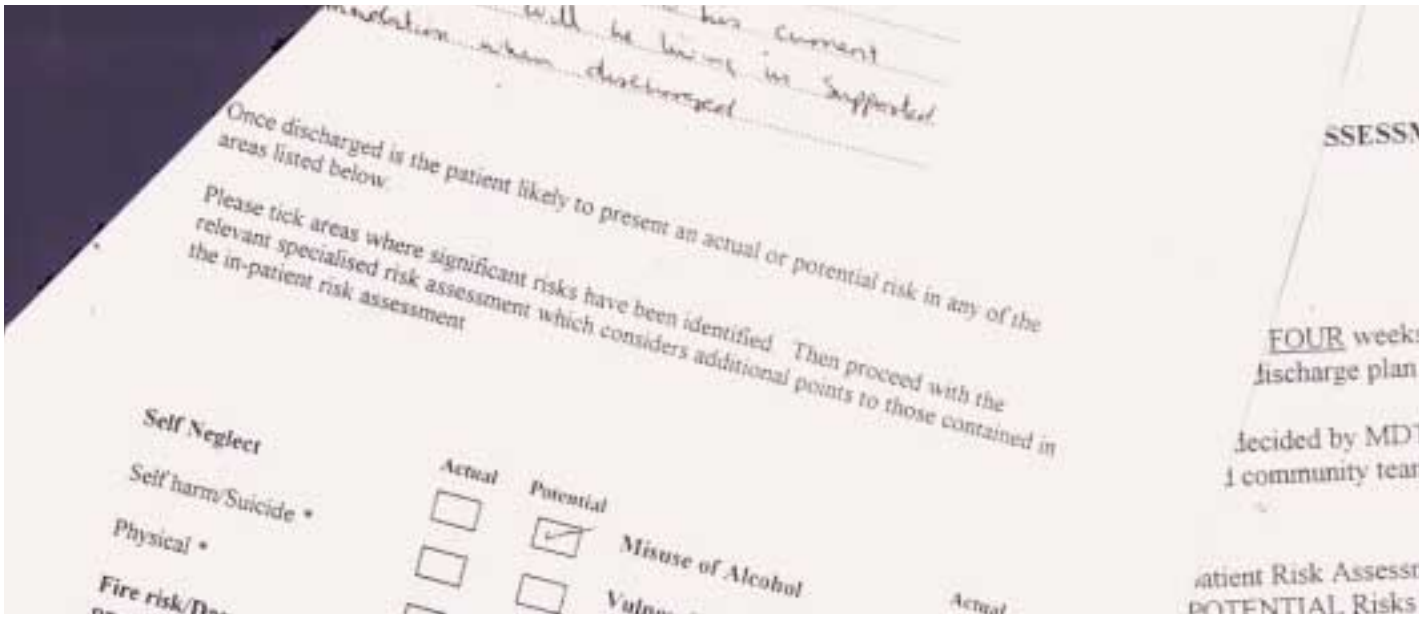
SOME readers of *The Psychologist*, or their friends or relatives, will have psychiatric treatment or admission imposed on them at some time in their lives. With their professional hat on, psychologists are soon likely to be offered a lead role in this coercive process. Are we ready to accept it? Do we want to?

Under current legislation the notion of a 'responsible medical officer' (RMO) for detained patients only gives a backroom role for psychologists, as risk assessors, therapists or occasional expert witnesses for mental health review tribunals (which consider patient discharge appeals). However, the government's White Paper on the reform of the 1983 Mental Health Act (Department of Health & Home Office, 2000) replaces the notion of RMO with a new one of 'clinical supervisor'. The latter role could be taken up by a consultant psychologist (not just a medical practitioner) under the proposed new legal arrangements for England and Wales.

Given that the care regime of detained patients is governed, in the main, by compliance with physical treatments (drugs, ECT and psychosurgery), the times when a psychologist might become a 'clinical supervisor' will probably be limited to two specific circumstances. The first, and rare, scenario could be when detained psychotic patients are being managed solely or predominantly by a psychological, rather than physical, approach. The second, much more likely, circumstance will be the management of 'personality disorder' (PD). In the White Paper a new, broad, non-diagnostically based, definition of mental disorder is offered, as well as the reference to 'clinical supervisors', not RMOs. Also, the government has set out a separate joint Home Office/Department of Health statement on 'dangerous and severe personality disorder' (D&SPD) (Department of Health & Home Office, 1999), indicating their pressing need to deal with this client group under health, rather than criminal, legislation.

Within these recent government deliberations a limited evidence-based rationale for the psychological treatment of people with a diagnosis of PD has been recognised, whether carried out by psychologists or other professionals such as medical psychotherapists or probation officers (see e.g. McGuire, 1995). This nascent role for psychologists exists in a context of many general NHS psychiatrists eschewing PD patients because they are not deemed to be 'treatable' (Cawthra & Gibb, 1998).

Even forensic psychiatrists are not fully committed to treating this group (Cope, 1993), and many medium-secure psychiatric facilities currently do not admit people with a primary PD diagnosis. While the 'untreatability' position is being challenged increasingly by some mental health workers, a profound ambivalence



about responsibility for the open-ended risk management of PD patients remains evident. For example, 75 per cent of a sample of forensic psychiatrists questioned recently rejected the government's proposal to allow unlimited detention in unconvicted cases (Haddock *et al*., 2001). This ambivalence has been amplified by a politically invented notion of D&SPD appearing on the scene, which bears little relationship to the traditional professional discourse about PD (see below).

The rest of this article will explore some arguments about the wisdom of psychologists taking a lead in the coercive management of people with a PD diagnosis, given its dubious scientific status. Then we will examine a set of legal considerations for psychologists about the recent government proposals.

The contested status of 'personality disorder'

Psychologists researching PD should be wary of taking for granted the scientific status of the diagnosis. There are a number of fundamental problems with any such pre-empirical act of faith. The reliability of forms of PD, tested psychometrically against criteria from the *Diagnostic and Statistical Manual* of the American Psychiatric Association, has not been inspiring. Some subtypes of PD do not achieve test–retest coefficients of above 0.5 (Blanchard & Brown, 1998), suggesting considerable change in diagnosis over time. Even when they do, reliability is not validity.

With regard to validity, PD is not readily differentiated from either normality (e.g. scheming insincere politicians and consensual sadomasochists – see Pilgrim, 2001) or other psychiatric diagnoses (e.g. chronic neurosis – see Shepherd *et al*., 1968). There are no clear biological pathognomic markers, which would indicate a specific aetiology of PD. The diagnosis is made using circular logic, by applying behavioural criteria that persist over a sufficient period of time to warrant the status of the patient. This can be seen in relation to several forms of PD: 'antisocial' (a pattern of violent or sexually exploitative conduct, in current British law called 'psychopathic disorder'); 'histrionic' (recurring dramatic and manipulative insincerity); 'borderline' (a series of distressed and ambivalent attachments to others); and 'schizoid' (asocial functioning in those who are not mad).

We would argue that such forms of PD are defined by everyday evaluations of role failure or rule breaking. According to both their peers and examining professionals, PD patients participate in an adult moral order in some way or other inadequately. Their actions seem to warrant judgements from their fellows that they are significantly emotionally immature, self-centred, untrustworthy or immoral. Consequently, variants of the PD diagnosis are medical codifications of the violation of social norms. They are medicalised moral judgements about the failure to achieve mature autonomous adult functioning, judged in a particular social context.

This has been noted by some psychiatrists, who point out that PD patients have 'the worst of all possible worlds'. Mann and Lewis (1989) used this phrase to indicate that such patients are not granted the paternalistic sympathy usually allotted to people who are ill, nor are they respected as being normal and healthy. The authors also note that psychologists cannot always offer psychiatrists a clear consensus on the meaning of 'personality' in order to make diagnostic judgements about what, if anything, is 'disordered'.

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In a similar vein, Gunn and Robertson (1976) point out that the diagnosis is basically a 'derogatory moral judgement'. The latter cannot be persuasively 'scientised' away, by either psychiatry or psychology, as a reification called 'PD', because it arises from value judgements, not objectively measurable features of individuals independent of the interpersonal context and moral order they inhabit. This makes the notion of a 'personality' being 'disordered' logically problematic (Lawson, 1989). The diagnosis dates back to the views of early 'alienists', who emphasised its inherent moral status. Nothing has really changed, except maybe some of the words we now use in our attributions about forms of conduct in our midst that we despair about, fear or despise.

It is true that 'behavioural difficulties', indicating an emerging nonconformity in individuals, often start at an early age and so the diagnosis of PD usually refers back to a developmental trajectory (Rutter *et al*., 1999). However, this is a description not an explanation. Being good at soccer tends to start from a young age, but the reasons for this aptitude or ability are open to debate – so too with PD. Thus, a descriptive agreement on a biographical trajectory is undermined by a wide explanatory disagreement. Biological, psychodynamic, behavioural and cognitive models compete for pre-eminence in their aetiological speculations and linked therapeutic preferences. Consequently, 'treatments' for PD have included psychotropic drugs, hormone implants, psychosurgery, therapeutic communities and a variety of individual and group psychological therapy models, from psychoanalysis to cognitive therapy.

The weak legitimacy of the diagnosis of PD is undermined further, as noted earlier, by the lack of enthusiasm demonstrated by the psychiatric profession about the management of those with the label. This has contributed to the current social opportunity (or risk) for psychologists to move into an emerging, legally sanctioned, form of expertise. Whereas other psychiatric diagnoses, like 'schizophrenia' and 'depression', can also be criticised on grounds of weak reliability and dubious validity (Bentall *et al*., 1988; Pilgrim & Bentall, 1998), medical codifications of madness and misery are still enthusiastically promoted by the psychiatric profession as 'mental illness'. This medical enthusiasm is absent for PD.

Given this psychiatric caution about diagnostic and legal responsibility, we now turn to the professional challenges facing psychologists in an emerging new legal context.

Pressing legal clarifications

There is space here to mention only one or two of the most pressing questions that will, or should, trouble psychologists anticipating the role of clinical supervisor under new mental health legislation. The White Paper identifies the clinical supervisor as the 'the consultant with lead responsibility for the care of a patient with a mental disorder' and, in a departure from the 1983 Act, it adds '…normally a consultant psychiatrist, *but may also include a consultant psychologist*' (emphasis added).

Although we are told little about the specific powers to be contained in any new Act, there is the unequivocal statement that the clinical supervisor replaces the current responsible medical officer. With the exception of the power to initiate long-term compulsion, which is to be lost to the new mental health tribunal, it seems that the clinical supervisor will be able – and will be required – to fulfil many of the

functions of the current RMO. When performing these functions, the RMO may only be sued at the moment with leave of the High Court, which will only be given if there is a prima facie case that the function was performed in bad faith or without reasonable care (Hewitt, 2000). There is no parallel proposal in the White Paper in relation to clinical supervisors.

The White Paper says little about who will perform which duties: for example, the responsibility to devise a care plan is imputed somewhat vaguely to the 'clinical team'. But the clinical supervisor will certainly be instrumental in this task. Once three days have elapsed, compulsion will only be possible if the criteria for long-term care and treatment are met (i.e. if the patient is deemed to be suffering from a mental disorder that warrants specialist care and treatment, and a care plan has been produced). It seems inconceivable that the complex assessments implied by these criteria will be performed by anyone other than the clinical supervisor. Compulsion will only be possible beyond 28 days with the approval of the new mental health tribunal. Unusually, the White Paper explicitly places responsibility for applying to the tribunal on the clinical supervisor.

The White Paper also contains proposals for dealing with what it calls 'high risk mentally disordered offenders'. Of new political significance is that in order to justify a therapeutic rather than a purely custodial disposal, the crime will have to be linked to the offender's mental disorder. This requirement is not contained in analogous provisions in the current Mental Health Act. Under the proposed arrangements, even after a practitioner has diagnosed personality disorder, and devised a treatment plan to address it, the clinical supervisor will have an additional task to perform in respect of some high-risk offenders. They will be involved in pre-trial remands for assessment or treatment, and, following conviction, in recommending a care and treatment order and any accompanying restriction order.

The White Paper says nothing about the criteria that are to govern whether a psychologist or a psychiatrist is selected to become a clinical supervisor in particular circumstances. This distinction is crucial, for if the selection is negligently performed, and adverse consequences flow, there is the prospect of litigation and unwelcome financial and organisational expense for professionals and their employers. The current standard test for clinical negligence will apply. Each act of selection will need to be shown to have been in accordance with 'a practice accepted as proper by a responsible body of medical men' [*sic*] skilled in psychology or psychiatry (*Bolam* v. *Friern Hospital Management Committee*, 1957).

The absence of such a professional consensus is unlikely to frustrate the operation of the '*Bolam* test', it will simply invite the court to substitute its own, less expert, view. If the role of clinical supervisor is to become an operational reality following the White Paper becoming new law, then there is an urgent need for psychologists and psychiatrists to come to an agreement on appropriate criteria and protocols for case allocation.

The greater the professional responsibilities that are placed on clinical supervisors, and on psychologists who agree to undertake that role, the greater will be the potential for legal challenge to the manner in which they are discharged. Where such challenges are based on an allegation of negligence, their merits will be judged according to the *Bolam* test. However, the application of that test to the new regime for mental health care may create difficulties not currently seen in most other areas of medical litigation.

'health professionals may be being manipulated for reasons of political expediency'

Let us assume that a male patient, who has been subjected to indeterminate detention, seeks to argue that he does not in fact fulfil the requisite criteria: that his PD has been incorrectly, even negligently, diagnosed or treated. In such circumstances how, after *Bolam*, might a responsible body of psychological opinion respond? Would it be possible to find any consensus over whether the patient's 'symptoms' were such as to constitute a personality disorder? Is there a clear agreement about what constitutes personality disorder in the first place? Is there any common view on which behaviours may be attributable to personality disorder and which may not, and how these might best be managed? If clinicians are unable to reach an accord, their authority runs the high risk of simply being supplanted by the courts.

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Although the absence of a professional consensus will not be a bar to claims in clinical negligence, it may support the argument that practitioners under any new Act should enjoy the protection currently available to the RMO under the 1983 Act. Any such argument should be made quickly, before the final shape of the new Act has been set.

Since the introduction of the Human Rights Act 1998 (HRA) public authorities, such as health authorities and hospital trusts, have been required to act compatibly with the European Convention on Human Rights (ECHR), and they may be sued if they do not. Although no liability will attach to particular individuals under the HRA, the proposals for the new clinical supervisor certainly create the possibility of a breach of the ECHR. The ECHR gives an enforceable right to compensation to anyone whose detention is found to be in breach of Article 5 (which lays down minimum procedural standards for state detention). It is certainly arguable that any perpetuation of the current restriction on legal claims against professionals acting under the 1983 Act would breach this right.

And the coming of the HRA creates a second problem. Article 5 also states that the 'right to liberty and security' may only be breached in certain circumstances. Amongst these are detention upon criminal conviction or 'for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants'. In the seminal case of *Winterwerp* v. *The Netherlands* (1979) the European Court of Human Rights held that the detention of a person of 'unsound mind' would only be lawful where: he or she had a true mental disorder; that mental disorder was proved by objective medical expertise and warranted detention; and detention did not continue for longer than the mental disorder.

The question has already been posed whether a 'personality disorder' is a true mental disorder. If it were not, there could be no authority under the *Winterwerp* reading of Article 5 for the detention of a personality disordered person who was not an offender (or who did not have an infectious disease and was not an alcoholic, a drug addict or a vagrant). This problematic point serves to support those who have argued that the notion of 'high-risk mentally disordered persons' could be a flimsily constructed pretext by our ruling politicians, allowing them to devolve responsibility, and thus blame, to clinical professionals for the social control of one aspect of actual or perceived danger to the (voting) public (Cohen & Baldwin, 1999; Mullen, 1999). If this point is fair then health professionals may be being manipulated for reasons of political expediency.

Finally, the HRA presents a further problem – to ensure compliance with Article 5 it will also be necessary to demonstrate the existence of mental disorder on the basis of 'objective medical expertise'. This will be much more difficult if the professional community cannot reach some form of consensus about the reliability, validity, aetiology and treatability of PD. We would suggest that such a consensus is likely to be difficult to achieve if empirical evidence and conceptual analysis are taken seriously by practitioners.

Conclusion

In this brief article we have addressed a professional and legal dilemma for psychologists that requires immediate consideration. The controversies about the status of 'personality disorder' noted at the outset are not merely about academic preferences and debates. They have serious practical implications for psychologists, when and if we begin to live with the clinical supervisor role proposed in the White Paper.

Three forms of urgent action are implied. First, the issue of personality disorder and the implications it has for the psychologist-as-clinical-supervisor must be debated fully within our discipline. Second, if the role is effected, then its practical application and the division of labour it implies need to be agreed with the psychiatric profession. Third, before volunteering for the incipient role, psychologists should be aware that, in its present form, becoming a clinical supervisor will substantially increase the possibility that they or their employers will be sued for negligence or for breach of the Human Rights Act. They should therefore seek reassurance on the above points, and make early representations to government, before agreeing to proceed any further.

■ *David Pilgrim is Head of Adult and Forensic Psychology Services, Guild NHS Trust, Preston, and Professor of Mental Health, Department of Sociology, Social Policy and Social Work, University of Liverpool. Tel: 01772 401670.*
■ *David Hewitt is a solicitor with Hempsons, Manchester, and Visiting Lecturer in Law at the University of Central Lancashire.*