

Mental health law and incapacity: The role of the Clinical Psychologist

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Abstract

From an academic clinical psychological perspective, mental health problems are seen as existing on a number of continua with normal functioning, rather than being explicable in terms of categorical diagnoses. Clinical Psychologists use clinical case formulations in their professional practice and are critical of the validity and utility of diagnosis. Psychologists also see mental health problems as stemming from disturbances in psychological processes. In turn, these processes may be disrupted by a variety of causes – biological, social and psychological. Nevertheless, we see disturbance or impairment of such psychological processes as the central issue in mental ill health. Mental health legislation should therefore reflect these perspectives in terms of the criteria for compulsory treatment and in terms of the procedures and practices governing care.

To an extent this is welcome in the Government's current proposals for mental health legislative reform. A basis of compulsion based on criteria rather than diagnosis is proposed, as are care plans rather than diagnosis and treatment. Clinical psychology, however, would go further. Since there seem to be differences between 'well' and 'ill' in terms only of the degree and nature of the disturbance of psychological process and the impact on functioning, this speaks to the nature of 'unsoundness of mind'. Clinical psychologists contend that it follows that mental health legislation is appropriate and necessary only if people are impaired in their judgement to the extent of being unable to make valid decisions for themselves.

It has been proposed that Clinical Psychologists could act as 'clinical supervisors' (the term which is to replace 'responsible medical officers'). If, indeed, mental ill health is the disturbance of complex, inter-related psychological processes, it makes perfect sense to employ psychologists to coordinate care and decision-making. Clinical psychologists are ready to take their place as partners with lawyers and psychiatrists.

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Clinical psychologists

Clinical psychologists are scientist-practitioners. We act as theoreticians, academics and researchers. We are also therapists and care managers. When working as therapists, we act as applied scientists – building on our research expertise and knowledge of the scientific literature to develop psychotherapeutic and other solutions through the systematic application of this analysis.

The core skills of a clinical psychologist are: assessment, formulation, intervention and evaluation¹. Assessment of psychological processes and behaviour is different from diagnosis, partly in the way in which the results of these assessments are placed within the context of the historical and developmental processes that will have shaped an individual.

Formulation is the summation and integration of the knowledge that is acquired by this assessment process². Psychological formulations attempt to explain why people are experiencing difficulties. They usually consist of a list of problems and possible psychological reasons for these³. Typically, a formulation will examine what events have happened in a person's life, and how they have interpreted and reacted to these. Formulations tend to change as the psychologists and their clients learn more about the problems. Formulations are designed to be hypotheses about the problems, which are tested out over time⁴. For example, a clinical psychologist might tentatively hypothesise that childhood sexual abuse may be important in the development of a client's problems. This would be explored, sensitively, in therapy in order to confirm or disconfirm the possibility and, if confirmed, to develop a therapeutic response. Psychological case formulations are complex. Psychologists are trained to link theory with practice, and therefore a formulation may comprise a number of provisional hypotheses, based on a large variety of psychological theories, each drawing on scientific research.

Intervention, if appropriate, is based on the formulation. This may involve one of the psychological therapies, but may involve training, supervision or the supply of expert evidence.

The nature of the phenomenon

Continua

Psychologists recognise that each individual's experiences are unique⁵. Diagnoses such as 'schizophrenia', 'manic depression' and 'personality disorders' have limited utility, validity and reliability. If a diagnosis is valid, it should predict prognosis. However, for example, the outcome for people with a diagnosis of schizophrenia is extremely variable⁶. Diagnoses should also have 'prognostic validity'. They should indicate what treatments will be effective. Again, however, responses to medication appear to follow from the individual problems a person is experiencing, rather than the diagnosis they receive. In one notable study, for example, people were randomly

1 British Psychological Society Division of Clinical Psychology (2001) *The Core Purpose and Philosophy of the Profession*. British Psychological Society, Leicester.

2 Hawton, K., Salkovskis, P. M., Kirk, J., & Clark, D. M. (Eds.). (1989). *Cognitive Behaviour Therapy for Psychiatric Problems: A Practical Guide*. Oxford: Oxford University Press.

3 Persons, J. B. (1989). *Cognitive therapy in practice: A case formulation approach* (Vol. 41). London: W Norton & Company.

4 Brewin, C.R. (1988). *Cognitive foundations of clinical psychology*. London: Lawrence Erlbaum.

5 British Psychological Society Division of Clinical Psychology (2000) *Understanding Mental Illness and Psychotic Experiences: A Report by the British Psychological Society Division of Clinical Psychology*. Leicester: British Psychological Society

6 Boyle, M. (1990) *Schizophrenia: A Scientific Delusion?* London: Routledge.

assigned to receive different medication. Delusions and hallucinations responded to antipsychotic medication and mood swings responded to lithium, irrespective of diagnosis⁷.

Statistical analysis, too, has revealed that the 'symptoms' of 'illnesses' do not, in reality, cluster together in the way predicted by the diagnostic approach. For example⁸ the correlation amongst psychotic symptoms has been found to be no greater than chance, and cluster analysis does not reveal patterns recognisable as diagnostic categories⁹.

The central issue in diagnosis is one of classification – the idea that particular psychological problems cluster together and can therefore be considered together. Plato referred to this as “carving nature at the joints”¹⁰. If diagnosis ‘carves nature at the joints’, it is assumed that the problems called ‘schizophrenia’ are different from the problems called ‘bipolar disorder’ in the same way that the breast of a chicken is different from the leg. On the basis of the evidence reviewed above, many psychologists believe that these distinctions are invalid, that diagnostic approaches to psychological problems do not reflect real ‘joints’ in nature.

This can (hopefully memorably) be summarised as suggesting that mental health is a sausage, not a chicken. You can identify the ends of a sausage, and distinguish them from the middle. You can even choose to cut out a burnt bit. But there are no joints at which to carve, just decisions to be made. With respect to mental health legislation, an important practical conclusion follows. We cannot separate humanity into ‘mentally ill’ and ‘healthy’. The distinctions between those ‘of unsound mind’ and those of us lucky enough to avoid the Mental Health Act are subtle. They are also judgements about where to draw lines on continua. Similar continua exist in law and medicine that may be informative in comparison. Obesity is a useful and important term. But the spread of ‘fatness’ in the community is continuous. It makes sense on practical and clinical grounds to draw a line at a particular point on that continuum to distinguish the ‘obese’ from the rest. Or, in law, it makes sense to draw a line between adults and minors. But nobody believes that there is a developmental discontinuity on the stroke of midnight of an adolescent’s 18th birthday. ‘Adulthood’ is determined pragmatically. And it differs and is flexible. Laws related to sexual consent, voting, standing for parliament, driving etc, use (for eminently reasonable reasons) different cut-off points. And rulings like *Gillick*¹¹ suggest that the ‘fuzziness’ of these distinctions is recognised by the judiciary. Yet, at present the law, like medicine, relies heavily on dichotomous distinctions – guilty vs not guilty, negligent vs not liable, competent vs incompetent, well vs ill. Adherence to a continuum model would imply the need for a psycho-legal enquiry into this interface.

7 Moncrieff, J. (1997) Lithium: evidence reconsidered. *British Journal of Psychiatry* 171 113–119.

8 Slade, P.D. and Cooper, R. (1979) Some conceptual difficulties with the term “schizophrenia”: an alternative model. *British Journal of Social and Clinical Psychology*. 18: 309–317.

9 Everitt, B.S., Gourlay, A.J. and Kendell, R.E. (1971) *An attempt at validation of traditional psychiatric*

syndromes by cluster analysis. British Journal of Psychiatry 119: 399–412.

10 Hamilton, E. & Huntington, C. (1961) *The Collected Dialogues of Plato*. Princeton University Press. Princeton, N.J. p. 511.

11 *Gillick v. West Norfolk and Wisbeach AHA* (1985) All ER 373

Psychological processes

The continua of dysfunction in mental health are related to the disturbance of normal psychological processes. People who experience anxiety to the extent of receiving a diagnosis of an anxiety disorder show extreme versions of relatively normal processes. We all pay attention to threats, frightening things absorb our attention (we'd be in some danger if we ignored threats). Anxious people seem to take this tendency further, overemphasising danger, catastrophically misinterpreting signs of danger and ignoring material that signals safety. They may also excessively engage in normal processes such as performing reassuring rituals. People who are depressed tend to interpret information in a negative way. For example, they see the glass as half-empty, not half-full¹².

Such distortions of normal processes occur for explicable reasons. Traumatic, abusive or unpleasant events during a person's childhood can affect the way that the person interprets information and reacts to events later in life. People with mental health problems commonly report having had highly distressing or traumatic life experiences such as bereavements, abuse and assault¹³. Because everybody interprets new events and challenges in the light of previous experience, such experiences affect the ways people respond to life's challenges and in the ways new experiences are understood.

One early theory of 'schizophrenia' was that it reflected a 'loosening of connections' in the brain¹⁴. (That idea is reflected in the term 'schizophrenia' meaning 'fragmented mind'). Psychotic experiences such as hearing voices, unusual beliefs and 'thought disorder' appear to involve making unusual connections between apparently unrelated events. This is not in itself either good or bad. Sometimes making unusual connections between things is valuable, when it is termed 'lateral thinking' or 'creativity'. In fact, people who score highly on measures of 'schizotypy' also score highly on measures of creativity¹⁵. It is even possible to imagine how the ability to make creative connections could be a genetically inheritable trait. Many studies have shown that people who have unusual or delusional beliefs tend to 'jump to conclusions' when faced with limited or contradictory information¹⁶.

Psychologists believe that many mental health difficulties result from a combination of these normal, but distorted, processes. For example, if you are feeling confused and experiencing overwhelming emotions, you may find it particularly hard to interpret other people's actions and intentions accurately. This might mean that interactions with other people are very anxiety provoking and ambiguous. If the events in your life have led you to believe that people tend to abuse and hurt you at every opportunity, and you also have a tendency (again exaggerated in a state of stress) to jump to conclusions, it is understandable that you might occasionally feel paranoid.

12 Brewin, C. (1988). *Cognitive foundations of clinical psychology*. London: Lawrence Erlbaum.

13 Romme, M.A.J. (1998) *Understanding Voices: coping with auditory hallucinations and confusing realities*. Runcorn, Cheshire: Handsell Publishing

14 Bleuler, E. (1911/1950). *Dementia praecox or the group of schizophrenias* (Zinkin, E., Trans.). New York: International Universities Press

15 Schuldberg, D., French, C., Stone, B.L. & Heberle, J. (1988) *Creativity and schizotypal traits. Creativity test scores and perceptual aberration, magical ideation, and impulsive nonconformity*. *Journal of Nervous and Mental Diseases*. 176(11): 648-657.

16 Huq, S. F., Garety, P. A., & Hemsley, D. R. (1988). *Probabilistic judgements in deluded and nondeluded subjects*. *Quarterly Journal of Experimental Psychology*, 40A, 801-812.

Centrality of psychology

Such an analysis places psychology at the centre of mental health. While psychologists universally acknowledge that biological factors and the social environment, together with psychosocial experiences and learning, contribute to mental health, their perspective is that illustrated in Figure 1. Psychologists do not believe that there are ‘genes for schizophrenia’ or even that ‘schizophrenia is a brain disease’. Within a psychological perspective, a variety of factors must be considered to have an impact on mental health, but not directly. Psychologists view biological, social, environmental and psychological causes as having impacts on underlying or mediating psychological processes. It is dysfunction of these processes that results in mental ill health.

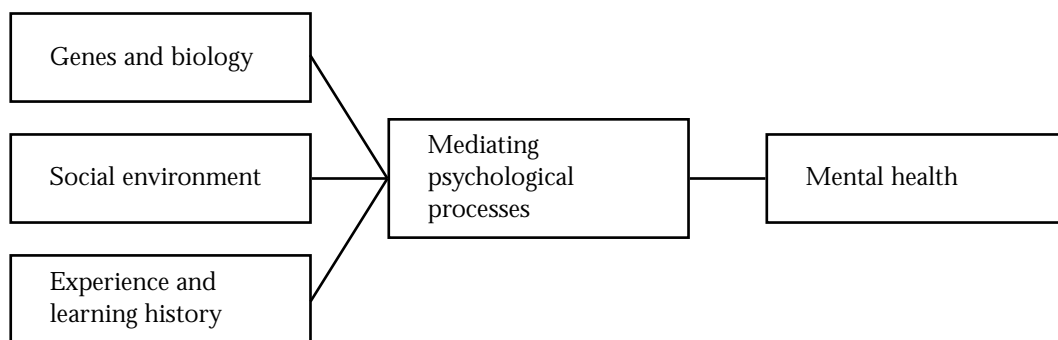


Figure 1. The relationship between causes, psychological processes and mental health.

Capacity

Within such a framework then, there are few valid places to ‘carve nature at the joints’ when it comes to mental health. The central issue in mental ill health is the disturbance or impairment of psychological processes. Such disturbances lie on continua. There are many such continua, because there are many psychological processes that contribute to mental ill health.

In the context of mental health legislation, the most important continuum is impairment of judgement. Many psychological dysfunctions impact on the ability to make sound and consensual judgements. Impairment of judgement, or incapacity, also relates most appropriately to ‘being of unsound mind’.

The European Convention on Human Rights, enshrined in the Human Rights Act 1998 of course applies to mental health legislation, and includes the fundamental human right to liberty and security of person (Article 5). It explicitly allows for exemptions in the case of persons ‘of unsound mind’. This term is not defined in either the Convention or the Act, but case law some 23 years old has referred to people with “real illnesses” (*Winterwerp v The Netherlands*, 1979)¹⁷. Clearly, people cannot be considered to be unsound of mind warranting compulsory detention and treatment, merely by virtue of having a diagnosable mental illness, since one person in four¹⁸ is likely to meet such a criterion and this would imply that one can pass such a threshold if one has, for example, a phobia of snakes.

¹⁷ *Winterwerp v The Netherlands* (1979) EHRR 387

¹⁸ Kaplan, H & Sadock, B *Comprehensive Textbook of Psychiatry*. Williams and Wilkins. Baltimore (1989).

And both the Mental Health Act 1983 and the present proposals for reform of that Act make reference to mental disorder 'of such a nature or degree' as to warrant compulsory treatment. The 'nature or kind' of disturbance of psychological functioning that relates sensibly to 'unsound mind' is the extent to which individuals are capable or incapable of making relevant decisions for themselves.

The obvious implication is that people are of 'unsound mind' if they lack the capacity for making valid consensual decisions. This is relatively straightforwardly tested by assessing a person's ability "to understand or retain the information relevant to the decision, including information about the reasonably foreseeable consequences of deciding one way or another or of failing to make the decision" and their ability "to make a decision based on that information" in respect to a particular decision¹⁹.

Impairment of judgment, continua and personality disorder

An important aspect of present proposals to reform the Mental Health Act is the focus on public protection from people who are thought to pose a significant risk of serious harm to others. The present proposals have been widely discussed and essentially permit presumptive and preventative detention of people whom a professional believes might commit an offence. There is a definition of a new group of high risk patients – people who are considered "high risk as a result of Dangerous and Severe Personality Disorders". This uses a broad, vague and circular definition of 'dangerous and severe personality disorder', a definition yet to be subjected to empirical test. It is circular because people are identified as having a personality disorder by virtue of certain behaviours (including committing violent crimes), which are then seen as "arising from [the] underlying disorder" to quote the White Paper.²⁰

From a psychological perspective, there are serious scientific flaws in this stance. First, labels are not causal explanations. One cannot have behaviours 'arising from' what is a socially-constructed label describing those very behaviours. As with other psychological problems, continua clearly best describe the true state of affairs. To distinguish 'Dangerous and Severe Personality Disorder' from normal behaviour may solve practical and political problems, but it is an arbitrary decision on a rather vague continuum.

Many (but by no means all) people with a diagnosis of 'personality disorder' can be seen as having legal 'capacity'. The needs and risks of such people should be managed through consensual services and criminal justice mechanisms respectively. Because such a legal framework does not exist, there have not been legal, or psychological, tests of impaired judgement in personality disorder. But it is relatively easy to see people who would meet the DSM-IV criteria for antisocial personality disorder who retain capacity and also people with this label who would fail a test of capacity based on impaired judgement. I have in mind a sexual predator who fails, or is unable, to appreciate the seriously damaging consequences of his behaviour on his victims and their families. In the decisions surrounding consensual sexual behaviour, such considerations appear vital to making valid decisions. Depending on the case, of course, I could consider such vital failings in what is termed 'theory-of-mind' – appreciating the perspective of another – would render that person's judgement impaired to the point of being incapacitated with respect to that particular decision.

19 London. *The Law Commission (1995) Report on Mental Incapacity*. The Stationery Office. London.)

20 *Reforming the Mental Health Act. Part II. High Risk Patients* (Department of Health; the Home Office) (2000) Cm 5016 – II.

As well as being scientifically flawed, then, the present proposals are dangerous. People who have committed no crimes, and who retain the capacity validly to decide their own lives will be subject to compulsory detention and treatment under a mental health aegis because they are believed to be potentially dangerous. People's future dangerousness cannot reliably be predicted from their mental health history.²¹ It can be predicted on the basis of past violent or criminal behaviour. The public could be better protected from dangerous individuals with a straightforward amendment to sentencing policy – a change recommended by at least three government enquiries or commissions.²² Unlike a spuriously medicalising mental health approach, such an approach would be compatible with the Human Rights Act.

A variable threshold of impairment

Finally, impairments of judgement themselves are best thought of as lying on a continuum – or a series of criteria, individual to the different judgments. Legal criteria should, logically, differ for different situations. The legal tests of unfitness to plead, not guilty by reason of insanity, and diminished responsibility all imply capacity and impairment of judgement. It is not unreasonable to suggest that the legal thresholds necessary for judging capacity in respect to decisions involving no risk, risk to self and risk to others may be different. We do, of course, have different criteria for assessing the competence of judgement-making capacity necessary to sanction allowing people to decide how to organise their own personal relationships and the judgement-making competence considered sufficient to license a person as a barrister – capable of representing one's clients in a court of law – or a psychologist – capable of assessing competence!

The role of the Clinical Psychologist

The government is proposing that the current 'Responsible Medical Officer' role should be replaced by that of 'Clinical Supervisor', and that Clinical Psychologists could fill this role.²³ If, indeed, mental ill health is the disturbance of complex, inter-related psychological processes, it makes perfect sense to employ psychologists to coordinate care and decision-making. This paper should be interpreted, in part, as a call for psychological understanding to be placed centre-stage in mental health legislation.

Some psychologists welcome this development, seeing it as a means of introducing psychological perspectives into decisions about compulsory treatment, whilst others fear that it might compromise our professional values. In a recent survey, however, 70% of clinical psychologists responding stated that the profession of psychology should be open to this development, and 51% stated that they would be willing to be a clinical supervisor if offered appropriate training.²⁴

Such responses should not be taken to imply approval of other plans for reform. Eighty-two percent of respondents agreed that people should only be subject to mental health legislation if their judgement is (permanently or temporarily) impaired to the extent that they are incapable of

21 Bonta J, Law M, Hanson K. (1998) *The prediction of criminal and violent recidivism among mentally disordered offenders: a meta-analysis.* *Psychological Bulletin.* 123: 123–142.

22 For example, the *Report of the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital (1999)* Cm 4194 – II. The Stationery Office.

23 See Paragraph 29 of *Draft Mental Health Bill Explanatory Notes, Department of Health (2002)* Cm 5538 – II. The Stationery Office.

24 Cooke, A, Kinderman, P. & Harper, D. (2002) *Criticisms and concerns: Results of a survey of DCP members opinions about proposed reforms to the 1983 Mental Health Act.* *Clinical Psychology.* 13: 43–47.

making the relevant decisions for themselves, and 84% agreed that to call someone who is habitually violent “personality disordered” is circular and adds nothing to our understanding of the causes of, or likely remedy for, such behaviour.

Summary

Mental ill-health is, essentially and centrally, a psychological issue. Mental ill-health should be seen as the consequence of dysfunctional or impaired psychological processes. These processes may be impaired by biological, social, environmental or psychological factors, but such factors impact on mental health through psychological factors. Both mental health legislation and mental health care should reflect this reality. Individual multidisciplinary case formulations should be the basis of care. Incapacity – impairment of decision-making ability – should be the basis of mental health legislation.

With respect to the present Government proposals, the British Psychological Society welcomes the use of specific functional criteria under a broad remit of ‘mental disorder’. Psychologists, however, echo the concerns of the Health Select Committee, the Royal College of Psychiatrists and others that the current criteria remain over-broad, and likewise recommend the use of further limiting criteria.

The British Psychological Society therefore calls for the inclusion of a further specific criterion before compulsory care is legitimised. This would entail that the “the mental disorder is of a nature or severity so as to impair the individuals’ judgement to the extent that the individual is incapable of giving or withholding valid consent with regard to a particular issue or issues addressed by the care plan”.

Psychologists believe that such a criterion, coupled with the existing proposals, will ensure that vulnerable people are able to receive the care they need and that the public is protected from the few people whose mental disorder renders them dangerous. However, we recognise that this would not permit compulsion under a Mental Health Act for dangerous people whose judgements are unimpaired. The BPS does not believe that mental health legislation is an appropriate vehicle in such circumstances. Instead, psychologists recommend the use of further legal sanctions under the criminal justice aegis (entirely separate from mental health legislation). These may include the use of reviewable or indeterminate sentences and of the use of specific treatment orders and community supervision orders for people identified as being likely to reoffend. Psychologists will be willing to assist fully in developing these suggestions.

Clinical psychologists have much to offer mental health care and mental health law. They are ready to take their place as partners with lawyers and psychiatrists. Apologies will have to be given for the fact that our profession is some 4000 years younger than either law or medicine.