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Some thoughts on why clinical psychologists should not have formal powers under the new mental health act

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Part 1 of the government white paper "Reforming the Mental Health Act," proposes to give clinical psychologists powers regarding the detention and compulsory treatment of people. It is proposed that we have a role regarding assessment and detainment (as an "approved mental health professional") and a role in the process of ensuring that people comply with compulsory care plans (as "clinical supervisors"). As someone who has worked in a regional secure unit and a community mental health team, with people who have sectioned under the 1983 Act and along-side people whose daily work involves operation of the powers under the Act, I do not feel that overall this would be in the best interests of our clients or ourselves.

Do service users welcome the new act and psychologists having coercive powers under the act?

Although service user groups have welcomed some of the safeguards built into the new Act, they do not welcome the potential extension of the powers of the Act to a very wide group of people. Clinical psychologists may have campaigned for or welcome the remit of the Act not being based on medical diagnoses, but the definition to be used means someone could be detained and treated against their will if they "have a temporary disorder of mind which results in a disturbance of mental functioning and it is in the patient's best interests." With such a wide remit it is likely that the Act will be used in a discriminatory way against people who have the least power in our society, for example black people, poor people, people who are not very articulate and who have been poorly educated.

Service user groups are campaigning against the emphasis in the Act on compulsory treatment, especially compulsory treatment in the community. Service users want more access to a wide range of help, including psychological interventions, and want these to be offered on the basis of informed consent. No service user groups have campaigned for psychologists to be involved in compulsory powers. I am not aware of any service user group who believe psychologists would be better at this type of work than other professionals.

How will compulsory care plans affect our clients and our relationships with them?

Although I have worked with people who have said they were grateful that they had been sectioned and detained, all of those people recognised that at that point they had lost significant capacity to judge for themselves what would be best for them. It is important to recognise that the new Act is not based on capacity but is based on a

loose definition of mental health problems. I have yet to meet anyone who felt compulsory treatment was beneficial. Many people, men and women, have likened forced medication to being raped, something that many of them had previously experienced. Many people have felt damaged by their experiences of compulsion, and have not trusted psychiatrists and other mental health professionals since. The likelihood is that we will be bracketed with psychiatrists and social workers as agents of the state whom people are very wary of when it comes to describing their difficulties. This has to be counter-productive to a profession that practices therapies, which are based on trusting relationships and the disclosure of disturbing thoughts, feelings and impulses. It is hard to imagine us being able to take an effective role as an advocate if we have formal powers to compulsory detain and treat people.

Do coercive care plans work?

Fisher and Greenberg (1997) present convincing evidence that the beneficial effects of psychiatric drugs are only significant when both patient and prescriber expect the drugs to help. All therapies have best outcomes for people who are highly motivated to engage in them. It remains unclear how we will helpfully compel people to do behavioural exposure programs, keep cognition diaries, make links between the past and present, or escape the racism, poverty or abuse that might be causing their problems. In fact, I have yet to meet a psychologist who has said how s/he will compel someone to comply with a care plan that they do not want to do, apart from by detaining them in our already overfull and understaffed hospitals. But then what?

It is important to note that we will only become clinical supervisors for people who are “resisting or considered likely to resist proposals for assessment and treatment or not complying with an existing treatment program” (criteria for compulsory powers 3.16). For people whom we have devised appropriate care plans we will be care managers or key workers (as we can be now) not clinical supervisors – the role only comes into effect when people refuse to do what mental health professionals have deemed is in their best interests. In my CMHT none of the care plans are dominated by psychiatric treatment; rather they are characterised by help for people to get better housing, escape oppression and abuse, get access to training, education and jobs, receive counselling, etc. However, all of the workers are at a loss as to how this could be forced on people who do not want it.

Does compulsion reduce risk?

The evidence for this is not clear. Some medications have been shown to increase risk of harm (e.g. Healy, 2001) whereas overall rates of suicide and harm by people with diagnoses of mental illness appear to relate to other factors (e.g. the economic cycle) rather than medication or other treatments. The new Act is a response to a concerted media and lobbying campaign by groups like SANE rather than evidence about people with mental health problems (e.g. homicides by people with diagnosed mental illness have not been rising, Taylor and Gunn, 1999). It presumes that psychologists and other professionals can predict risk accurately despite enormous research evidence (e.g. Crawford, 2000) indicating that such a process is fraught with difficulties. It is widely accepted that to get over any meaningful threshold of risk prediction regarding violence the person must have committed a violent act in the past. If this is so then people who have not committed crimes (and who retain

capacity) should not have their liberty taken away and receive enforced treatments on the basis of risk assessment. Poor people are more likely to steal but does that mean we should lock up all poor people? Risk assessment has become an obsession in mental health work with insufficient professionals arguing against the belief that we can accurately predict other people's behaviour even though common sense tells us it is impossible – I can't even predict how my partner or two year old daughter are going to react to things so how can I be expected to make predictions about people I've only just met?

Will we operate the act more humanely than other professions?

This is one of the main arguments put forward by supporters of our involvement with the Act. Famous experiments by social psychologists and others have shown that people's behaviour is frequently significantly changed by the roles that they take up. For example, the experiment that put people at random into the roles of jailers or detainees had to be stopped when the behaviour of the jailers became too abusive (within 2 days). Perhaps we need more humility regarding how much better or more humane we would be in comparison to our colleagues?

If we did not have formal powers would we be just 'burying our heads in the sand' or can we work effectively without these powers?

I have worked effectively to ensure that people seen by the team I work in are not overmedicated, have care plans that take account of or are solely based around psychological rather than psychiatric perspectives, and relate to the type of help people are seeking and feel will help them recover or escape from their difficulties. I have not needed formal powers under the Act to ensure this – rather having psychiatrists and other mental health professionals who are willing to accommodate these practices and there being funding for support services and investment in local communities have been the crucial factors. This will remain so even under the new Act. I cannot see how being clinical supervisors will give us additional power to effectively get other professionals to change their practices or will enable us to do anything more about the underlying causes of someone's distress.

Is it better to get involved and try and change the system from within?

Given the limited number of clinical psychologists and ever increasing burden on mental health professionals to assess rather than help people, I believe we would be more effective concentrating on what we have been trained and are experienced in doing – working collaboratively with clients. Of course, it is possible to do this with people who have been detained, but crucially this involves them making an informed choice to meet and work with us rather than us being clinical supervisors forcing them to do things. Many psychologists have spent enormous amounts of energy (sometimes whole careers) trying to change intransigent systems and institutions such as hospitals – I believe that our energies are best spent working where we can be most effective and taking a critical stance on things from the outside which we feel are harmful or unethical.

Will we have more power to improve services?

In my Trust psychiatrists seem to have had very little power in the last five years to set up or shape services, this being dominated by managers following a government defined agenda. By doing some of the work traditionally carried out by psychiatrists I am sceptical as to whether this will give us any more power to shape these services.

Will we get more pay?

We think we will, but approved social workers haven't. We think we will get the same pay as psychiatrists but the government has never offered this. And anyway, is this kind of envy a good reason to make such a change in our professional lives?

Do we need more work? Do we want to be 'called out' on weekends, evenings or have to drop whatever we are doing to deal with people not consenting to treatment?

I thought psychologists had enormous waiting lists and substantial demands on their time to provide things that they have been trained to do – therapy, consultation, supervision, and training? It is unclear how many of us could do this and be involved in work under the Act. It can take two days to organise a section under the current Act and the proposals under the new Act mean it will be even more lengthy and bureaucratic with requirements to fill in forms and produce reports at short notice. Are we going to cancel our other clients? Are some of us only going to do this work, because it does not readily fit with a planned weekly diary of client work, supervision and training? What will our families think when we are called out in the evenings or weekends because we are now part of a system of 24hour care/monitoring?

Will we be able to opt out?

Once we are more integrated into the state's ways of monitoring and controlling people the state will have more power over us, including the power to insist that psychologists take on the role of clinical supervisor. Employing trusts are most concerned about carrying out work decreed by statute so are going to want to employ psychologists who will be clinical supervisors rather than those who might refuse.

Will it split the profession?

In my opinion the DCP are running the risk of splitting the profession. One set of people will take on the role of clinical supervisors and the expert, paternalistic role that entails. Others, who want to work on the basis of collaboration, informed consent and mutually agreed goals, will refuse on ethical grounds to do Mental Health Act work. My impression is that more recently qualified people fall into the latter camp. It might be that wiser, more experienced clinicians are leading us down a road that younger, less experienced people are wary to go. On the other hand it could be that people in managerial roles who are never going to do any of the sectioning or compulsory treatment themselves are committing a group of people with different ethical and professional beliefs to work that they object to.

One solution might be to create a separate job of forensic psychologist. It is clear that many people who work in forensic settings welcome the proposals in the Act and suffer difficulties that differ from people in community settings (see Black, 2001). The role of compulsion regarding people who have committed offences raises different ethical and human rights issues compared to non-offenders. But as it stands, the new Act brings compulsion to a group of people who are no more likely to offend than any member of the general population, and in doing so is inherently discriminatory.

Final thoughts

Before speaking at the DCP debate on the white paper I asked a consultant psychiatrist and social worker in my CMHT what they thought about clinical psychologists having formal powers regarding detention and compulsory treatment in the new Act. This is what they said:

“One effect of having formal power under a mental health act is that it skews every assessment that I do. I always have two hats on – the ‘how can I help you’ hat and the ‘how can I protect the community (or yourself) from you’ hat. Sectioning someone often massively damages the relationship that I can have with a client. Some clients hate psychiatrists and social workers because of what they have done to them or their family members in the past, or are (rightfully but unhelpfully) wary of us; I guess the same would become true of psychologists.

Sectioning is the worst aspect of my job. It is emotionally damaging to both clients and myself. I become like a policeman carting people away, often not because I want to but because of pressures from family, other members of the community and mental health workers who are at the end of their tether. Because everyone feels so helpless about how to help someone I become the agent of social control. Unlike Larkin I believe that it is this, rather than my parents, that ‘fucks me up.’

It is important to have a non-medical perspective with people detained or coerced under a mental health act, but I don’t see why psychologists can’t do this without having to take a formal role under the Act.

Although I do believe that it can be of help to someone to section them under the Act it isn’t something I entered the profession or spent all those years training to do. I would give anything not to have to do it.”

Consultant Psychiatrist

“You will become like social workers – disliked and not trusted; people won’t want to see you. You will become part of the system and end up doing the work of the system, even if you don’t think you will. You will detain and coerce people who live in communities that you would never live in – not on behalf of their community but on behalf of the state.

You will have power to remove people from shitty situations but after they have been put in hospital they will eventually come out to the same shitty situations because you won’t have the power to improve their living conditions, family relationships, working

conditions or neighbourhoods. You will have less and less time to help people or do community work as all of your time gets taken up with operating the Act – it can take 2 days work to organise a section. Ambulances won't come, policemen won't come even when there are violent people in the house, or when they do they come with blue lights flashing and scare everyone. You will go into frightening neighbourhoods and meet people who you have never met before, who might have long histories of violence, knives or guns, be drunk or on drugs.

You will be on call days, evenings, nights and weekends. Your profession will change; you will start telling untruths to people who are critical of the system you are now at the heart of. Do psychologists know what it is like to do this kind of work? You should stay independent – in fact be even more independent.”

Social Worker

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