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# Tensions between policy and practice: A qualitative analysis of decisions regarding compulsory admission to psychiatric hospital

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ABSTRACT

The use of detention for psychiatric treatment is widespread and sometimes necessary. International human rights law requires a legal framework to safeguard the rights to liberty and personal integrity by preventing arbitrary detention. However, research suggests that extra-legal factors may influence decisions to detain. This article presents observational and interview data to describe how decisions to detain are made in practice in one jurisdiction (England and Wales) where a tension between policy and practice has been described. The analysis shows that practitioners mould the law into 'practical criteria' that appear to form a set of operational criteria for identifying cases to which the principle of soft paternalism may be applied. Most practitioners also appear willing, albeit often reluctantly, to depart from their usual reliance on the principle of soft paternalism and authorise detention of people with the capacity to refuse treatment, in order to prevent serious harm. We propose a potential resolution for the tension between policy and practice: two separate legal frameworks to authorise detention, one with a suitable test of capacity, used to enact soft paternalism, and the other to provide legal justification for detention for psychiatric treatment of the small number of people who retain decision-making capacity but nonetheless choose to place others at risk by refusing treatment. This separation of detention powers into two systems, according to the principle that justifies the use of detention would be intellectually coherent, consistent with human rights instruments and, being consistent with the apparent moral sentiments of practitioners, less prone to idiosyncratic interpretations in practice.



## 1. Introduction

The use of compulsory hospital admission for psychiatric assessment and/or treatment is a relatively common practice in many countries (Riecher-Rossler & Rossler, 2007). However, there remains little consensus regarding the circumstances under which it is morally justifiable to use such compulsion, since it deprives the person of their liberty and the legal criteria authorising compulsory admission vary considerably between different jurisdictions (Appelbaum, 1997; Fistein, Holland, Clare, & Gunn, 2009).

International human rights law requires a legal framework to safeguard the rights to liberty and personal integrity of people affected by mental ill-health by preventing arbitrary detention (United Nations, 1991; World Health Organization, 2003). Nonetheless, legal scholars have repeatedly questioned the effectiveness of mental health legislation as a means of protecting the human rights of people receiving psychiatric treatment (Appelbaum, 1997; Gostin, 2008). Empirical research also raises questions regarding the effectiveness of much of this legislation as a safeguard for human rights; for example, rates of detention are not necessarily lower in jurisdictions with stringent legal criteria constraining the use of compulsory admission, nor do they necessarily decrease when a jurisdiction enacts new law with stricter criteria (Zinkler & Priebe, 2002; Salize & Dressing, 2004).

The reasons for this gap between 'policy' and 'practice' are not fully understood. A body of research based upon clinicians' accounts of their decision-making processes suggests that a complex constellation of factors may influence the decision to detain (Bagby, Thompson, Dickens, & Nohara, 1991; Engleman, Jobes, Berman, & Langbein, 1992; Kullgren, Jacobsson, Lynoe, Kohn, & Levav, 1996; Hoge et al., 1997; Sattar, Pinals, Din, & Appelbaum, 2006). The role of individual differences in the way risk is assessed by clinicians (Bartlett, 2010) and the role of 'gut instinct' based upon professional experience (Glover-Thomas, 2011) have also been highlighted as factors affecting day-to-day mental health decision making. Psychiatrists' accounts of the way in which they learn to make these decisions, through observation of the practice of colleagues,

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and normally without the benefit of formal training in legal principles, has been cited as an explanation of the discrepancy between policy and practice (Wand & Wand, 2013). However, there is limited recent observational research describing the processes by which actual decisions to admit are made (Holstein, 1988; Quirk, Lelliot, Audini, & Buston, 2000).

The aim of this study was to describe the ways in which decisions to detain are made in one jurisdiction (England and Wales) where a tension between policy and practice has been described. We sought to understand the reasons behind day-to-day mental health decision making, to describe the principles on which actual decisions were based, and to analyse how and why they might differ from the legal framework that defines the circumstances under which lawful detention may take place.

In England and Wales, the circumstances under which someone may lawfully be detained in hospital for psychiatric assessment or treatment are defined in the *Mental Health Act 1983 as amended 2007* (MHA). Most compulsory psychiatric admissions are authorised on the grounds given in Section 2 or 3 of the MHA. Two medical practitioners (one of whom has particular expertise in the diagnosis or management of mental disorders) and a specially trained Approved Mental Health Professional (AMHP), who must have a non-medical professional qualification (often, but not necessarily, social work), must agree that the legal criteria for compulsory admission apply.

Section 2 authorises detention in hospital for a period of up to 28 days, for the purpose of assessment. The criteria are that the patient

- *is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment* (*or for assessment followed by medical treatment*) *for at least a limited period*; *and*
- *he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons.*

Section 3 authorises detention in hospital for a period of up to six months and can be renewed. The criteria are that the patient

- *is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital*; and
- *it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section*; *and*
- *appropriate medical treatment is available for him.*

The 2007 MHA amendments came into practice in November 2008 and effectively relaxed the criteria for compulsory admission (Glover-Thomas, 2011). These changes were the result of a decade-long debate and were opposed by key stakeholder groups who expressed concerns that the amended Act weakened safeguards for the rights to liberty and self-determination of people at risk of detention (Mental Health Alliance, 2007). In contrast to the mental health legislation of many economically developed countries, there is no requirement to establish that the patient poses a risk to the safety of themselves or others, or that they lack the capacity to make a decision to consent to treatment.

Two years before the amendment of the MHA, the parliament had enacted another new piece of legislation, the *Mental Capacity Act 2005* (MCA), which sets out criteria for the provision of care and treatment (for physical or mental ill-health) deemed necessary in the best interests of people who are unable to give consent, as a result of impairment or dysfunction of mind or brain. In April 2009, additional safeguards concerning in-patient treatment and residential care for people who lack the capacity to give or withhold consent, the MCA Deprivation of Liberty Safeguards (MCA-DoLS) came into force to ensure compliance with Article 5 of the European Convention on Human Rights, as interpreted through a body of case law (Winterwerp v the Netherlands [1979] ECHR, Litwa v Poland [2000] ECHR, HL v UK [2005] ECHR).

The deprivation of liberty is said to occur in circumstances where a person is under continuous control and supervision, is not free to leave, and lacks capacity to consent to these arrangements (*P v Cheshire West and Chester Council and another and P and Q v Surrey County Council* [2014] WLR 2). A deprivation of liberty is lawful only if it represents

- *a proportionate response to the likelihood of* [the patient] *suffering harm and the seriousness of that harm*

and if the person authorizing that restriction

- *reasonably believes that it is necessary … in order to prevent harm to* [the patient]

Detention under a MCA DoLS authorisation may be considered less stigmatising, as unlike the MHA there is no connotation with detention for public protection. However, access to independent review and appeal against MCA DoLS authorisation is less straightforward. If a patient objects to the hospitalization or to any of the treatment they will receive there, a MCA DoLS authorisation cannot be granted and detention under the MHA is the only available option.

Consequently, it appeared that the people who decide whether or not to use compulsory admission for psychiatric treatment would be making those decisions within a relatively complex regulatory framework with two key pieces of legislation, one of which potentially conflicted with their professions' values or their personal moral intuitions (Roberts, Peay, & Eastman, 2002). Furthermore, the interface between the two frameworks is complex and poorly understood (Clare et al., 2013; House of Lords Select Committee on the Mental Capacity Act 2005, 2014). It remains unclear what the implications of this state of affairs might be for clinical practice.

Understanding the ways in which the new legislation was implemented in practice could potentially highlight the need for specific training or for further law reform. Furthermore, a detailed description of the principles upon which decisions to detain are based in practice, and the way decision makers justify any departure from the legal framework, has broader implications for understanding and addressing the gap between policy and practice that has been observed in multiple studies involving a large number of jurisdictions (Appelbaum, 1997; Zinkler & Priebe, 2002).

## 2. Methods

Over a 12-month period, we collected data on the ways in which decisions to detain people under Section 2 or Section 3 of the MHA were made by medical practitioners and AMHPs working in the catchment area of a mental healthcare provider in the East of England. The study comprised two components:

1) Direct observation of medical practitioners and AMHPs discussing whether adults they had assessed met criteria for compulsory admission and should be detained. These discussions were audio-recorded. In order to assist interpretation, the lead author (EF) also conducted and recorded brief (15–20 min) semi-structured interviews with the medical practitioners and AMHPs immediately after they had made their decisions, asking about the decision-making process.

2) In order to gain a broader understanding of practice than could be obtained through observation of a sample of MHA assessments alone, detailed interviews with medical practitioners and AMHPs, each lasting up to two hours, were also conducted. Following the data collection methods used in Biographic-Narrative Interpretive Methodology (Wengraf, 2001), participants were first asked to tell the story of their involvement with compulsory treatment over the course of their working lives. They were then asked to describe in more detail up to seven particular incidents of decisions to detain that they had mentioned in their stories. This approach was adopted in order to discover the factors that participants consider important

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