How do lawyers pursue the ‘best interests’ of clients with mental disorders?

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Abstract:
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Within the criminological literature surrounding people with mental disorders and their interaction with the criminal justice system, scant attention has been paid to the role of legal representatives. Lawyers’ decision-making in cases involving mentally ill clients is a significant topic because lawyers are in many respects ‘gate-keepers’: in practice, it is they who decide if psychiatric reports should be commissioned and if they should be disclosed; it is they who advise on the legal options open to their clients and the tenacity with which they are to be pursued. Literature which has touched tangentially on this issue seems to indicate that lawyers’ decision-making in this area may be made more complex by the clinical and legal interests of clients conflicting with or obscuring each other.

This study seeks to address this gap in the research: semi-structured interviews were conducted with eighteen lawyers who had experience of decision-making in cases involving hospital orders, either in Crown Courts or before Mental Health Review Tribunals. An analysis of themes emerging from this study has been conducted against the background of the literature dealing with medico-legal decision-making written by jurists and psychiatrists. The emphasis of this research is on gaining a lawyer’s perspective: how lawyers self-construct their professional role as regards to clients with mental disorders, and how their view of their role informs their decision-making in practice.
Declarations

I declare that this dissertation, excluding the abstract, dedication, acknowledgements, table of contents, references, appendices, and this page, is 17,999 words.

The appendices do not exceed 10% of the total length of this dissertation – the appendices are 1322 words, if adopting the table as having a nominal length of 200 words, or 1341 words in total.

This dissertation is entirely my own work and no part of it has been previously submitted for any degree, diploma or other qualification.

Mary Elizabeth Cowe

1st of June, 2012
For my parents
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Chapter 1: Law and Psychiatry: An Overview of the Terrain

“...at best, the prognosis is for an unhappy marriage of convenience” (Weisstub, 1978)

The interaction of law and psychiatry has generated a substantial literature; or more accurately, multiple disparate literatures which seem to be addressed to different audiences. The purpose of this dissertation is to make an integrative contribution by asking how lawyers negotiate the medico-legal terrain; in particular, how they understand their role in representing clients with mental disorder\(^1\). The decision to select this particular topic and to pursue an appreciation of it through the use of interviews is addressed directly in chapter two, but it will be best understood in relief, against the background of the various ways in which the relationship of law and psychiatry has been explored to date.

1.1 Psychiatrists and anti-psychiatrists

The psychiatric literature concerning the contribution medicine has to make to law has a distinct ethical orientation – a classic articulation of the anxieties which doctors face in contemplating forensic (courtroom) psychiatry can be found in the work of Stone (Stone, 1984) and in his subsequent exchanges with colleagues, which focus on whether such work involves a betrayal of the doctor/patient relationship and the Hippocratic imperative to do no harm. Equally, much of what has been said in defence of forensic psychiatry comes from an ethical concern that without the mediation of medical personnel, the law, characterised as ‘hard’ and inflexible, is likely to mechanistically produce unjust results in cases involving those with mental disorder (Appelbaum, 1994). A jurisprudential argument in same vein has been independently developed by Alan Norrie, who writes of medicine’s ability to act as a “safety valve for the law” by exonerating the ill or

\(^1\) The dissertation title refers to ‘mental disorder’ because that is the language of the statutes (Mental Health Act 1983; Mental Health Act 2007; hereafter “MHAs”) which govern the making and discharge of hospital orders in England and Wales. However, most American writers talk about ‘mental illness,’ as indeed did most of the interviewees. Unless specifically distinguished from each other, I employ the terms interchangeably without intending to refer to diagnoses or legal categories. I have not adopted formulations such as ‘psychiatric consumers’ (Arrigo, 1996) because this language does not seem to describe the reality of the defendant/patient’s interaction with the legal system.
mitigating their actions, whilst being complicit in the law’s project to portray behaviour as the result of individual rather than social pathology (Norrie, 2001).

It is through the consideration of factors relating to justice rather than health that American psychiatrists seem to forge a functional compromise to their ethical dilemma: recourse is made to arguments about the psychiatrist-as-expert having a unique duty to give the court the benefit of his expertise; a role distinct from the traditional duties of the psychiatrist-as-healer (Appelbaum, 1994). A dual professional life is envisaged: psychiatrists, striving to uphold ‘justice’ values of honesty and respect for persons, would testify in cases in which they do not have a pre-existing therapeutic relationship with the defendant/patient. This “American Solution” (O’Grady, 2002) is not open to clinicians in England and Wales, as one of the clinicians who gives evidence to the court before a hospital order is imposed must be “the approved clinician who would have overall responsibility for his case” (s 37(4) MHA 1983, as amended by s 10 (4) MHA 2007). A theory of mixed duties has been proposed which suggests that doctors should have regard to both justice and medical ethics to allow them to balance their role as impartial expert with their role as the defendant’s clinician (O’Grady, 2002). It is suggested that placing on psychiatrists the burden of “balancing the distribution of benefits and risks for the patient and society” (O’Grady, 2002) is ethically and practically untenable: it is difficult to see how one could balance the duties which adhere to these two very different and often conflicting roles, when the duties which flow from either purport to be absolute e.g., the doctor’s duty of non-maleficence and the expert’s duty of honesty to the court.

Psychiatrists may be adopting a quasi-judicial role of filtering evidence in order to reconcile these conflicts. The strong treatment bias and the existence of an established public health service in the UK is said to have resulted in psychiatrists working in an environment free of many American-style due process constraints (Beck, 1996). The UK system creates the temptation for psychiatrists to act as benevolent mediators between patients and the courts, and to assume the responsibility of blending scientific, social, legal and folk understandings of illness to form one master narrative, rather than adding the voice of the clinician’s perspective (Mullen, 2010).

Concern that as psychiatrists “drink in the intoxicating wisdom of the law” (Stone, 2007) they will be irresistibly pulled towards acting as zealous advocates putting forward a case
seems to run higher in the US than in the UK. It may be that the consumer-centric system of private healthcare and more frequent spectacle of ‘battles of the experts’ in court result in a greater scepticism about the nature of psychiatric knowledge (Mullen, 1996) – a scepticism rooted for some in an awareness that psychiatry is an infant science (Stone, 2007) and for others, in a belief that psychiatry is a pseudo-science treating illnesses which do not have an existential reality (Szasz, 2002). The fear is that if psychiatrists find that they cannot use their science to provide a basis for answering legal questions of competency, agency or responsibility, they may be lured to justify existing legal definitions rather than to inform legal decision-making. Ultimately, such psychiatrists will come to rely on ‘folk psychology’, which, although it incorporates widely held notions about the non-deterministic and rational basis of human agency, is “not a valid account of the human mind” (Stone, 2007). The basis of this ‘folk psychological’ model, the idea of agency, is something which has been termed inescapable due to the extent to which it informs our perception of ourselves and others (Morse, 2008); legal doctrines are heavily dependent on the idea of voluntaristic action: “The idea of free will in relation to conduct is not, in the legal system, a statement of fact, but rather a value preference having very little to do with the metaphysics of determinism or free will... Very simply, the law treats man's conduct as autonomous and willed, not because it is, but because it is desirable to proceed as if it were” (Packer, 1968).

1.2 Anti-Lawyers

The description of psychiatry by those who doubt its ability to secure health as “a semantic strategy for medicalizing economic, moral, personal and social problems” (Szasz, 2002) is echoed in the words of those who doubt the ability of law to secure justice; particularly justice for those whose actions seem to defy explanation, as the law is said to be “inadequate to deal with those whose style of existence does not comport with the ordered, logical, reasonable point of view” (Arrigo, 1996). This understanding of the law as an oppressive institution, systematically privileging particular viewpoints, would lead one to conclude that psychiatry is apt only to extend its repressive regime, rather to enable the law to better accommodate the contradictions of human behaviour beneath a voluntaristic façade (Norrie, 2001). The conception of psychiatry adding nuance to legal conceptions of rationality would enable one to consider attempts to humanize the law
through therapeutic jurisprudence with some optimism (Wexler and Winick, 1996); however if oppression is in the very shadow of the system, such techniques are likely only to increase the reach of the therapeutic state.

Those who hold to a belief in the essentially unjust nature of the law are without answers as to what a lawyer representing someone whom he thinks lacks capacity/competency ought to do: Arrigo puts securing treatment and defending rights in permanent opposition to each other, and believes that the legal system is not an appropriate way to achieve either goal. It may be that psychiatric or folk psychological narratives do not capture the full lived experience of someone with a diagnosed mental illness - but in practice treating someone diagnosed with a mental illness as though there was no such diagnosis may not necessarily enoble that person. If such persons are caught in the criminal justice system, they may be left without recourse to a way of making their histories understandable.

The unconcern for the ‘psychiatric citizen’ who is also a criminal defendant seems in part to be attributable to the sentiment that, if there must be casualties in “re-conceptualising justice” (Arrigo, 1996), it is better if those casualties fall among those who are bad as well as mad. Like some of the anti-psychiatrists (Morse, 1982; Szasz, 2002), Arrigo is content that consideration should be given to de-criminalising petty crimes and re-imagining social toleration: however, those who commit serious crimes would not benefit from an acknowledgement of the impact that any mental disorder may have had upon their actions. This seems to be an inconsistent position which reinforces the folk psychological notion that anyone who does something ‘very wrong’ must have known what they were doing.

1.3 Legal Perspectives

For those who locate their research or analysis within the existing legal framework, the overriding dilemma is not about the existential reality of mental disorder: it is about the practical problem of how to deal justly with those who suffer from it. Three concerns are consistently voiced: that there is a mismatch between legal and psychiatric definitions of mental disorder; that advocates adopt a different, less confrontational, perhaps less zealous posture in hearings that involve psychiatric defences or disposals; and that mental
disorder is greatly more prevalent among those who are policed, prosecuted and incarcerated than in the general population.

The last concern is the least controversial: the prevalence of mental disorder in prisons is widely accepted to be significantly higher than in the general population, although definitive figures are hard to arrive at given methodological differences as to inclusion of different conditions and surveying techniques. A meta-analysis of sixty-two surveys examined the rate of psychotic illness, major depression and personality disorder in twelve western countries and found that psychotic or major depressive illness was two to four times higher in prison than in the general population of Britain or America, and that diagnoses of anti-social personality disorder were approximately ten times higher (Fazel and Danesh, 2002). It would seem that despite different attitudes to the right to treatment and due process in either country, the mentally ill are substantially over-represented in both English and American prisons.

1.3.1 Legal language and medical concepts

A review of the literature written in professional legal journals in England and Wales reveals a perhaps unsurprising focus on the language of the law. The antique phrasing in which the fitness to plead test and the insanity defence are expressed, with an exclusive emphasis on cognition rather than affective or volitional capabilities, has been a source of long-standing complaint (Law Commission, 2010). Yet, it may be that the focus on legal language stems not only from substantive contests about the meaning of quasi-medical terminology, but from the inclination of lawyers to solve problems through narrower appeals to interpretation rather than broad appeals to principles.

This is not to say that the many articles and case commentaries which have been written about the interaction of law and psychiatry evince an unconcern with normative issues; but legal criticism seems naturally focussed on addressing them obliquely with reference to individual scenarios. For example, in order to challenge the view that the insanity defence could have application only when defendants did not know that what they were doing was legally (rather than morally) wrong, Professor Mackay summarised the facts and rationes decidendi of many cases to highlight ‘movement’ in the law (Mackay, 2009). Lawyers are perhaps uncomfortable in making appeals to extra-legal factors which are of uncertain application, and prefer to move from many particulars to the general.
Within the legal perspective, this approach of lateral interpretation in a bid to find overall cohesion or integrity makes sense. The law aspires to achieve certain goals in terms of social regulation and co-operation in addition to doing justice between parties (Raz, 1979), and achieving these ends requires a consistency of approach between cases, a commitment to reasoning rather than caprice, and an at least theoretical acceptance that lawyers in applying the law have no mandate to substitute their wisdom for that of Parliament. It may be thought that it is this last consideration which inhibits legal critics (in the UK, at least) from explicitly making ‘horizontal’ appeals to higher order principles or suggesting innovative solutions which are socially desirable but have no pedigree of precedent behind them.

Outside the perspective of the law, this reliance on consistency and apparent belief in law being discovered rather than made by lawyers may seem a little removed from reality. For example, the Crown Court practitioner’s ‘bible’, Archbold, neatly explains the disconnect between medical and legal definitions of madness thus: “Insanity at the time of the commission of the alleged offence is merely a particular situation where mens rea was lacking...As the defence of insanity is based on the absence of mens rea, the mental condition recognised by the law as insanity for this purpose is not the same as insanity or mental illness as recognised by medical science” (Richardson, 2012). This might be thought to be true in only the narrowest of senses – it implies that there is some sort of principled, causal link between the construct of mens rea and the divergence between medical and legal models of madness. It ignores the fact that the concept of the ‘guilty mind’ is a folk psychological construct: there is nothing about the existence of such a concept which requires that legal rather than moral misunderstandings can excuse, or that disease of the mind may include some but not all types of diabetes.

It may be argued that in terms of the knowledge needed by lawyers to perform their roles, there is nothing wrong with questions of insanity being reduced to technical rather than social or historical questions. However, in practice these apparently technical questions are not answered in a moral or social vacuum: the law may be able to couch its reasoning in catechistic terms with narrowly framed questions inexorably yielding narrowly framed answers, but as the foregoing discussion may demonstrate, that does not prevent others posing broader questions about the implicit agenda behind such reasoning. It is not necessary to subscribe to a view of the law as an oppressive conspiracy in order to query
how apposite it is to maintain a pronounced emphasis on the status quo with regard to interpreting fluid constructs such as mental disorder.

Such an emphasis on stability might mean that greater attention is paid to maintaining the integrity of form over substance, leading to the piece-meal “search for order and rationality” proliferating contradictions (Hawkins, 2003). Thus, in *R v. Southwark Crown Court ex parte Koncar*, a Crown Court wished to make a hospital order under section 5 of the Criminal Procedure (Insanity Act) 1964 in respect of an unfit defendant who had been acquitted of all offences other than a summary offence which would normally be heard in the Magistrates Court. As Magistrates Courts are not empowered to make findings of unfitness or to act under section 5, the query was whether the Crown Court had a power to so act, in spite of the provision that it could only “deal with an offender” in a way in which a Magistrates Court could have dealt with him. The Divisional Court held that someone who was found unfit was not an offender, which had the merit of ensuring that the appropriate order was made in *ex parte Koncar*. However, the power conferred by section 5 is only exercisable through section 37 of the MHA 1983, and the jurisprudence dealing with sentencing under section 37 makes it very clear that those who fall to be sentenced under that section remain offenders and should be treated as such.

Cases such as *R v. Nafei* and *R v. Khelifi* state that the gravity of the offence, the existence of a causal connection between the offence and the illness, and policy matters such as deterrence can be considered in assessing the merits of hospital orders. These cases do not sit easily with *R v. Howell* which states that the fact that a court does not trust Mental Health Review Tribunals (MHRTs) to withhold discharge in appropriate cases is no reason to refrain from passing a hospital order; a case which itself seems to be at odds with *R v. I.A.* which allows courts to give “appropriate weight” to the different release regimes operated by the Parole Board and MHRTs.

With such a lack of clarity in the law about mentally ill defendants, the conclusion that those who have the responsibility of representing them suffer from “role ambiguity” is unsurprising (Warren, 1982). Before proceeding to discuss how contradictions engrained in the law may translate into the attitudes adopted by lawyers towards their role in court, it is right to note one area in which higher-order appeals to principle are accommodated within the legal framework: the rights-based critique of mental health legislation (for example; Prior, 2007; Davidson, 2002; Goonan, Heay and Moynihan, 2000).
Those who discussed broadly conceived rights, not tightly tied to any legislative framework (Goonan et al, 2000) were un-impeded by the need to consider how such rights might operate in individual cases. In this sense their critique is more broad-ranging than that of authors discussing European Court rulings. Such rulings reveal that the essential problem of balancing rights remains the same in whichever forum the issue is considered. However, the European rights-based critique is instructive in examining how this language of rights might find expression within the syntax of legal systems. The European Court’s explicit focus on balancing rights at least allows perennial problems to be re-cast in their most essential way, without reference to domestic institutional concerns: thus the European Court’s declaration that the lack of a power for MHRTs to discharge restricted patients was incompatible with Article 5 of the Convention resulted in tribunal powers being changed by the MHA 19832. When domestic courts run into legislative lacunae, they can often do no more than tentatively suggest that Parliament may wish to address an area afresh.

1.3.2 Representing the “Partly Mad and Partly Bad”

A striking lacuna in the literature is the topic of the quality of representation that mentally disordered defendants receive. Most of the criticism concerning the standard of representation received by the mentally ill is derived from observations of civil commitment courts in America, where there is significantly more judicial oversight of the involuntary commitment of those who have not committed criminal offences. The relatively neglected subject of the role of lawyers in representing mentally ill defendants on either side of the Atlantic may be the result of methodological problems: it would be difficult to determine in advance the extent of any defendant’s mental health problems, or the impact such problems may have upon their trial (whereas the existence of mental disorder can be assumed as being in issue in all civil commitment hearings). Even if such trials could be identified, it would be problematic to rely solely on court observations to comment meaningfully upon the effect of a defendant’s illness upon the efficacy of lawyers’ advocacy.

2 X v. United Kingdom
However, this inattention to the quality of representation received by mentally ill defendants may in part be the result of legal and psychiatric literatures perpetuating the view that those who are ‘both mad and bad’ represent an isolated, technical problem. This rhyming shorthand used parenthetically by many authors is necessarily reductive. Those charged with criminal offences are only *alleged* to be ‘bad’ or guilty, and may well wish to contest this ascription: the difficulty may be that they are required to choose or to have thrust upon them one label to avoid the stigma of the other. The anti-psychiatric literature pointedly neglects to engage with the issue of how those who are both ill and on trial should defend themselves without recourse to psychiatry. The psychiatric literature focuses on the ethical conflicts of the doctor and only obliquely refers to the practical problems of the patient/defendant. The criminal law seems to operate by considering the defendants as *defendants* throughout the proceedings, and then transforming some defendants into patients at their conclusion. Without a comparative study of MHRT and Crown Court advocacy, conducted with sensitivity to the fact that different forums may require different styles, one can do no more than speculate as to whether defendants/patients have their rights better protected, or participate more, in one forum or another.

Whatever the limitations may be of appraisals of advocacy based solely on observation of only one type of court, it is unlikely to be a coincidence that such advocacy has been consistently criticised in the strongest terms. Representatives’ advocacy have been variously described as “*disturbing*” (Hart, 1974); “*passive*” (Warren, 1982); it was “*rare for them to present these cases with vigour*” (Peay, 1989); and most forthrightly of all, “*a disgrace*” (Perlin, 2003). As lawyers cross-examine expert witnesses in insurance and medical malpractice cases with alacrity, it seems unlikely that it is the unfamiliar scientific terrain which leads to passivity. It has been posited that it is attorneys’ uncertainty about their duties to their clients which leads to half-hearted representation (Hart, 1974). These ambiguities were succinctly summarised by Warren in her seven-year study of a Californian court: “*attorneys view their clients as crazy and therefore refrain from standing firmly in the way of their involuntary incarceration*” (Warren, 1982). Warren describes new public defenders being initially zealous in their advocacy before

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3 Peay referred to MHRTs; all others to civil commitment hearings.
realising that they were the subject of comment, and then adjusting to “the practical ideal of all working together here” (Warren, 1982).

Peay generally presents a more positive view of representation than apparent in the American literature, highlighting the “therapeutic benefits” it could bring, although the role of the representative is no more than alluded to in her 1989 study. The lack of attention which representatives’ advocacy receives in a work about tribunal decision-making is itself instructive. Tribunals overwhelmingly took the course suggested by the Responsible Medical Officer (as they were then designated). During the course of the three year study, there was a concordance rate of 86% between the views of the RMO and the action taken by the MHRT. In over-thirds of the cases in which the MHRT and the RMO disagreed, the MHRT took a more cautious approach, sometimes disagreeing with the united opinion of hospital and independent medical reports (Peay, 1989). A more recent study emphasised that the medical member’s opinion was even more determinative of outcome than that of the RMO, which would seem to give advocates little scope: “members’ opinions on discharge rarely changed after the written evidence had been read” (Holloway and Grounds, 2003). An unsettling suggestion which emerges is that the knowledge they will almost certainly be unsuccessful leads representatives to only make focussed, vigorous applications for select cases (Peay, 1989). However, observations of advocacy before one type of court are not a firm basis for drawing definitive conclusions about the interaction between clients’ mental disorder and lawyers’ advocacy – without comparison with other forums or discussion with the lawyers, one cannot discount the possibility that MHRTs simply attract uninspiring advocates.

Whether characterised as a selective use of lawyers’ best efforts (Peay, 1989), deference towards a “common-sense topos” (Warren, 1982) or “folk psychology” (Stone, 1984), it is apparent that the gulf between law and psychiatry may be easily bridged in practice, if lawyers and doctors work to a unified, outcome-focused agenda - working towards what ‘makes sense’. Whilst Warren states that a common-sense model of madness is as legitimate as “unproven psychiatric or genetic theories or contextually absurd legal assumptions” (Warren, 1982), it might be argued that the imprecision of such a mixed model is inherently dangerous. A lawyer representing a mentally ill defendant may work with the common-sense model insofar as it informs the view taken by a judge, jury, psychiatrist or opponent. However, it may be thought that if one works within this
common-sense model of illness and illness management, one becomes unable to evaluate the fairness of the compromise it may represent. Such a model also assumes that decision-makers have such insight into what represents a good outcome for the defendant/patient that this issue does not require discussion. None of the commentators who describe the shortcomings of representatives does so with meaningful reference to professional, ethical duties. One of the difficulties with adopting ‘the achievement of a common-sense outcome’ as a lawyer’s duty is that one cannot have a duty to common sense. Placing reaching a consensus at the heart of a lawyer’s function inevitably de-centres the client, and the course of justice, from being the first objects of a lawyer’s duty.
Chapter 2: The need for a lawyer’s perspective

“We do not need theories, so much as the experience that is the source of the theory”

(Laing, 1967)

Something which emerges strongly from the foregoing literature review is the lack of consensus about whether or not consensus itself is desirable or achievable between lawyers and psychiatrists. Those who place the greatest distance between the professions as seeking after irreconcilable ends are either academic anti-lawyers (Arrigo) or psychiatrists who would not appear in court for reasons of principle (Stone; Szasz). Among those who countenance forensic psychiatry there is a tension between some who believe psychiatrists should have regard to justice ethics and considerations outwith their own professional discipline (Appelbaum; O’Grady), and others who believe that forensic psychiatrists are clinicians who give evidence, rather than courtroom experts who happen to specialise in psychiatry (Mullen).

Texts and opinions written from a legal perspective characterise the ‘partly mad and partly bad’ as an exclusively legal problem, and often a technical legal problem. It may seem trite to say that ‘lawyers look for answers within the law’, but it only appears so because of the conventional image of the lawyer as someone who, unconcerned with social problems, honours the letter of the law rather than making purposive enquiries as to its spirit (Norrie, 2001). The gap which exists in the literature is a lawyer’s perspective, rather than a legal perspective. Psychiatrists illustrate their theoretical positions with a first-person narrative, exploring practical and ethical problems which are always going to involve personal judgment: the legal literature tends to involve apparently impersonal ‘submissions’. Whilst this is unsurprising given the practical ends to which it is addressed, it renders it difficult to do more than speculate as to how lawyers make decisions in practice, and how those decisions translate into advice and advocacy.

The literature on legal decision-making mainly focusses on judges: it is generally accepted that judicial decision-makers can be influenced by extra-legal factors (Gelsthorpe and Padfield, 2003; Kapardis, 1984; Konečni and Ebbeson, 1984). Whilst judicial decision-making remains “shrouded in mystique” (Peay, 1989), these decisions
at least are highly visible; generally being delivered before the parties if not the public, requiring the giving of reasons, and potentially capable of appeal. It suggested that an exploration of the decision-making undertaken by lawyers in representing the mentally ill is overdue, considering the greater invisibility of this process, the power imbalance between those advising and those advised, and the difficulty that clients may have in challenging or remedying the effects of such decisions.

In this study, lawyers’ decision-making is explored in conjunction with a discussion of how lawyers view their own professional role: it is theorised from the psychiatric literature that role and decision-making will influence each other, but it is further argued that the addition of a lawyer’s perspective to the literature has an intrinsic value. Lawyers are a different population from the marginalised groups about whom exploratory studies are often conducted, yet they share the some of the features of these groups, existing within a rather closed world and having their experiences obscured by stereotypes.

The research question “how do lawyers pursue the ‘best interests’ of clients with mental disorders?” reflects two sub-concerns: ‘best interests’ is parenthesised to indicate that is a term of art, a term with a technical meaning which occurs in lawyers’ codes of conduct. I shall seek to explore both (a) lawyers’ decision-making: how lawyers decide upon the best interests of their clients; whether they view clinical and legal best interests as being in conflict; and how they mediate such conflicts; and (b) a lawyer’s role; lawyers’ understanding of what it is to be a ‘good lawyer’ and how this understanding of their profession impacts on their day-to-day interactions with mentally disordered clients.

2.1 Sampling

Some of the methodological problems with observation-based studies of advocacy as a means of examining the interaction between client illness and lawyers’ actions have been discussed above (1.3.2 pp. 8-10). Given that this study seeks to generate qualitative data touching on lawyers’ inner landscape of beliefs and their approach to decision-making, rather than exploring the results of their decision-making (such as courtroom
performance), it was decided to perform a small number of semi-structured interviews. Interviews also allowed participants to develop their thoughts at some length. The interview sample included lawyers who appeared before both Crown Courts and MHRTs. This was done: (1) to address the neglected topic of the representation available to defendants with mental disorders; (2) to examine whether variations in advocacy may be a result of lawyers’ beliefs that they fulfil different functions in MHRTs and Crown Courts; (3) because it may be thought the two arenas share sufficient similarity to make any contrasts instructive.

The sample was limited to those with experience of Crown Court cases in which hospital orders were made or actively considered, or those who have sought the variation or discharge of such orders before MHRTs. This focus on orders made by criminal courts allowed for comparison to be made between the styles of representation a defendant/patient may receive at different parts of the process. It was further theorised that ethical and practical dilemmas may be most acute in respect of criminal defendants or forensic patients, given the dimensions of public safety and public opinion. This focus on those who have gone through the criminal courts is also in part the result of the researcher’s own background at the criminal bar. This personal experience must shape the desire to add a lawyer’s perspective to the extant literature as a useful practical counterpoint to both the legal nihilism of Arrigo and the therapeutic optimism of Wexler and Winick.

In order to avoid ‘legalistic’ discussions, the sample comprised of lawyers unknown to the researcher who knew only that she was an MPhil criminology student. Whilst a small sample of eighteen lawyers cannot reflect a complete range of views and does not attempt to be generalizable, an attempt was made to avoid an in-built bias to homogeneity: participants were neither ‘snow-balled’ nor were they directly contacted through chambers and firms with a reputation for being ‘at the forefront of mental health law’.

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4 One survey-based study of decision-making by American health care (clinical negligence) lawyers yielded difficult to interpret findings, given the narrow range both of scenarios presented and of methods of lawyers’ self-description (focussing on ‘religiosity’) (Perry, Moore, Carrey, Clayton and Carrico, 2009)

5 Notional interview length was 60 minutes; interviews ranged from 40 – 140 minutes, with a modal length of approximately 75 minutes.

6 Lawyer 18, who asked the researcher directly if she was at the Bar, is an exception.
This was also done to ensure participants did not feel under pressure to speak for their profession.

In order to generate a sample of relevantly-qualified lawyers with possibly more diverse working practices, the Criminal Bar Association and the Mental Health Lawyers Association were contacted and agreed to email their members a request for interviewees. It was hoped that a sample with mixed levels of experience would allow for some consideration of professional enculturation, and such a sample developed organically. It was suggested that interviews should take place in person in London or Cambridge; a number of people based outside this area or particularly busy at the time responded suggesting telephone interviews. Prospective participants were assured that their on-going duties of confidentiality to clients would be respected, and that only generalised information was sought. The only encouragement which it seemed appropriate to offer possible participants was that it was an opportunity to communicate their views on the realities of a subject often treated as only of academic interest; and that they could receive a copy of the completed work.

2.2 Sample Composition

Details of the composition of the sample are outlined in Appendix One. Participants were reassured that limited personal information would appear in print to guarantee their anonymity. Accordingly, place of practice is not linked with individual lawyers. Those interviewed had appeared before tribunals and courts all over the country; two were based in the Manchester area, one in Nottingham and one in Cambridgeshire. The majority were London-based, travelling to courts throughout the South-East; more junior barristers would go further afield and most of the solicitors were part of firms who provided MHRT representation nationally.

As a further attempt to preserve confidentiality, a (rounded) number of years of qualification was adopted as a neutral way of giving an impression of the sample’s range

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7 Criminal solicitors also appear in Crown Courts: the Criminal Law Solicitors’ Association were contacted but did not confirm that the email requesting interviewees was circulated. None of the interviewees said they were CLSA members.
of experience rather than going into detail about individuals’ practices: the sample ranges from those with one to those with thirty-seven years qualified experience. All those currently practising as solicitors did a high proportion of mental health tribunal work and for many it was their exclusive area of practice. One barrister indicated that up to 50% of his work involved dealing with cases involving mentally ill defendants; a typical pattern seemed to be that as barristers progressed in their career, some became known for dealing with ‘difficult clients’, and cases with defendants with learning disabilities and mental health problems were increasingly diverted to them. Even those with such a reputation dealt with only a handful of hospital order cases annually.

Many members of the sample had a longstanding interest in issues surrounding mental health and psychiatry beyond requisite professional knowledge: either due to personal experiences, their previous professional background as police station representatives or drugs counsellors, or academic interest. One lawyer had co-authored a book on the subject; another had advised the Law Commission on reforming fitness to plead; three had an interest in the area through their study of criminology.

One might expect that only those with definite, likely critical, views on the subject of mental health practice would be attracted to an interview which offered no greater incentive than the opportunity to express those views. An attempt to mitigate possible volunteer bias was made in that details of interview questions were not sent out to participants; interviewees knew only that it was their experiences of this type of work which was of interest. It was felt that the disclosure of particular topics might yield a sample of polarised opinions e.g., those with particularly positive or particularly negative views about working with psychiatrists.

A greater number of Crown Court lawyers were ultimately interviewed; there was greater difficulty in arranging convenient times to meet more peripatetic tribunal lawyers. An explicit reference to the possibility of telephone interviews may have secured a more evenly balanced sample, although face-to-face interviews were theorised to be generally more appropriate (see 2.3). In order to address this imbalance, the Crown Court lawyers were asked about any experience they had of MHRTs. Three had some experience, either as an erstwhile ‘side-line’ or as a Tribunal Judge. Thus eight out of eighteen interviewees
had varying degrees of familiarity with MHRTs, including three barristers who were able to contrast their experiences.

2.3 Interviews: format, coding, analysis

Conducting “depth” interviews in person was felt to be an appropriate way to build the rapport necessary to explore values rather than simply gather facts (Jones, 1985). Interviews conducted in person lasted longer and were more participant-led; telephone interviews generally yielded slightly less discursive answers and were necessarily more dependent on verbal prompts. The interviews were semi-structured to allow participants to shape the interview around those themes which resonated with them whilst retaining some topical focus. Interviews were loosely structured around the legal stages at which lawyers have to consider issues of mental illness to provide concrete talking-points e.g., fitness, capacity, conduct of the hearing. There was an attempt at every stage to discuss the factors which affected lawyers’ decision-making and what lawyers considered their role to be.

A pilot interview was conducted with a MHRT Judge to assist in formulating questions for MHRT lawyers, as the researcher was unfamiliar with tribunal procedure and wanted to ensure that the areas selected for discussion were of relevance. The Judge was a former tribunal solicitor who was able to give an insight into the changes in mental health work over three decades; emphasising in particular the continuing judicial awareness of how this work is reported in the media and the impact of ever tightening resources on the conduct of hearings.

The experience of writing up notes after the un-taped pilot interview prompted the purchase of a small digital recorder on which subsequent interviews were taped. Participants were reassured that the recordings would be deleted at the end of the research, and all consented to be recorded. Interviews were manually transcribed; the first two were transcribed verbatim and thereafter only key passages were transcribed in this

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8 Although it was a relatively informal meeting to discuss areas of questioning, the Judge kindly sought Ministry of Justice prior approval lest the interview touch on matters relating to capacity as an office-holder.
way. Substantial passages in many of the interviews involved participants making detailed reference to particular cases – the intricate details were often less important than the type of specific, often reoccurring situation that the participant was seeking to illustrate. Transcription took place in three or four batches whilst interviewing was ongoing. The number of questions asked in later interviews decreased noticeably, the researcher having noted from earlier transcripts that shorter prompts lead to more wide-ranging answers. Two interview excerpts are included in appendix two to give an impression of the relatively discursive answers often given by interviewees.

An iterative analysis of the transcripts was conducted, which involved moving from predetermined codes derived from a review of the literature and the pilot interview (e.g., ‘risk’, ‘understanding’, ‘due process’), to codes which emerged from an inductive process of re-reading the transcripts and noting themes or tensions which seemed to echo (drawing on Strauss and Corbin, 1990). The latter type of codes tended to refer to complex processes and often involved legalised language (‘making the client’s instructions work’). Once coding began, the researcher had occasion to reflect upon the idea of role as it was a word used directly by many of the interviewees in a variety of ways; from meaning a specific function relative to a particular case e.g. “in a trial as to whether he had done the acts alleged...our role is to assist the court” (Lawyer 1); to a seemingly more essential meaning: “I never forget my role; I’m their lawyer. I’m not their social worker, I’m not their friend” (Lawyer 8). The situational emphasis that lawyers adopted in reasoning and in reflecting upon their role brought to mind an article by Anthony Kronman about the effect of “living in the law” on the development of situational judgment (Kronman, 1987). This led to the consideration of other works which dealt with virtue ethics and professional culture. The themes which emerged from re-reading the transcripts in light of these works are digested in chapter four, which draws together lawyers’ perspectives on their role and how this applies to the representation of mentally disordered clients.

Firstly, chapter three deals with themes and factors which seemed to emerge as having an impact upon legal decision-making in either forum. Individual quotations in the following chapters are not definitive of any lawyer’s position on any subject: views and emphases often changed within interviews and were frequently qualified. Quotation is necessarily
selective and influenced by the researcher’s reading of any one transcript in the context of all the others and the other literature.
Chapter 3: “Decisions and Dilemmas”

“A concern for the making of decisions by legal actors is important because law is the most consequential normative system in a society” (Hawkins, 1986)

In general terms, the decision-making of those interviewed can be conceptualised as something which occurred along a continuum. There was a balance between an acceptance that internal factors such as training, knowledge and inter-personal skills impacted upon the quality of decisions, and an emphasis on (resisting) the constraints of setting: “there’s a limited resource of time and energy” (lawyer 18); “money is a constant” (lawyer 9). The continuum can be thought of as involving background conditions of greater or lesser freedom. At one end of the spectrum were ‘decisions’ which effectively involved lawyers “ratifying” courses of action which were faits accomplis. Lawyers’ described fighting systemic factors such as bureaucracy or business-pressures which could lead to the scope of their decision-making being constrained. At the other end of the spectrum were finely-balanced exercises of professional discretion: for those involved in MHRT work, this type of decision-making was discussed in relation to the breadth or narrowness of issues raised at tribunal. Crown Court lawyers’ different scope of decision-making is a function of the legal context in which they operate, and the fact that a complete acquittal is not just an option in the Crown Court, but the result the barrister is geared to obtain.

Crown Court lawyers often envisaged themselves as dealing with binary outcomes (prison or not-prison), and saw optional psychiatric evidence as something they could introduce to facilitate an acquittal or help secure treatment: although some were to acknowledge that “hospital is not a panacea” (lawyer 8), Crown Court barristers chiefly conceptualised treatment as a positive alternative to prison. Barristers acknowledged their relative ignorance about what happens to defendants after sentence; one described being seen by probation as being “at the end of the legal system, before they fall into the deep” (lawyer 16). This half-jesting characterisation reflects barristers’ awareness that their understanding of what constituted a beneficial course of action was conditional on their

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9 (Peay, 2003)
10 (Hawkins, 1986)
own knowledge: many felt they ‘knew’ prison, and spoke of its hardness and its unsuitability for those with mental disorders. Conversely, tribunal lawyers did not conceptualise their work as being about minimising hospital and maximising ‘not-hospital’ outcomes, but in broader terms, as instrumental to the achievement of desirable goals for clients, perhaps over a number of years. Tribunal lawyers may have more immediate influence over a wider variety of possible outcomes than Crown Court barristers (e.g., discussing treatment pathways or seeking to ensure a good relationship between client and clinician), but a strong sense emerged that tribunal lawyers involvement with these wider aspects of a client’s case was increasingly viewed as a matter of personal choice rather than professional obligation.

These reflections on decision-making can be contrasted with Hawkins’ theory of primary and secondary decision makers (Hawkins, 1986): the former are theorised to make highly visible binary decisions which influence inclusion or exclusion from a process (e.g., juries deciding on guilt), and the latter make less visible analogue decisions which are about status or movement within a process (e.g., officials allocating prisoners to wings). An accumulation of secondary analogue decisions may have a great impact on later primary binary decisions, and may transform subsequent decision-making into ratification rather than a free exercise of discretion.

However, Hawkins’ theory does not directly address the decision-making performed by lawyers: whilst the MHRT lawyers could influence analogue decision-making, and Crown Court lawyers seemed to operate within a field of more binary decision-making, the dual taxonomy of primary and secondary decision-making does not seem to capture either set of lawyers’ positions in the process. Perhaps part of the reason that lawyers’ decision-making is rarely studied - relative to judicial or bureaucratic decision-making - is a lack of appreciation of or appetite for the possibility that lawyers’ decisions may have far-reaching consequences on the work of more visible decision-makers. If judicial decision-making is ‘higher-level’, it is also more remote from the raw material of the decision – their ability to take a view of the evidence or of the defendant/patient is mediated by the way in which the evidence or individual is presented by their lawyers. This mediatory process may be particularly important when decision-making occurs at the interaction of legal and medical “decision-frames” - framing a decision (e.g., as being clinical or legal) is “not only an interpretative act...it is also a classificatory act,
prompting particular decision outcomes” (Hawkins, 2003). This part of the study is concerned with what influences the ‘first-hand’ decision-making of lawyers operating in this apparently mixed terrain.

3.1 Perspectives on decision-making in the Crown Court

3.1.1 Identifying Illness

The decision about whether a defendant is ‘fit to plead and stand trial’ is central to the subsequent conduct of that defendant’s case. The fitness test is not concerned with a defendant’s ability to fully participate but with their ability to give instructions, although its inability to effectively discriminate between defendants who are capable of so doing has been repeatedly and vehemently criticised (Law Commission, 2010). The issue of unfitness is usually raised by defence representatives who are often best placed to assess if a defendant has communication difficulties. In an important way, defence counsel act as ‘gate-keepers’: in practice, the decision as to whether or not to get a psychiatric report rests with them. An appreciation of how psychiatric issues may impact upon a case will be relevant to lawyer’s advising on issues other than fitness, including the availability of psychiatric ‘disposals’ or defences. Defences other than insanity or diminished responsibility may be affected by the defendant’s mental state e.g., issues such as intention and foresight.

A key constraint on defence barristers’ decision-making in this area is their ability to identify mental disorder: a common theme was “if you aren’t looking for it, you won’t find it”. Six of the thirteen barristers strongly expressed concerns that mentally ill defendants were not being identified by the Criminal Justice System: this was said to happen “without a shadow of a doubt” (lawyer 13). In addition to citing the over-representation of the mentally ill in prison, they gave personal accounts of occasions in which they, colleagues, or opponents had ‘missed something’ which became apparent later. Barristers were particularly concerned about the co-existence of mental health problems, learning disabilities and alcohol and drug dependencies: “I think there are an

11 Other aspects of the test include being able to challenge jurors and understand oaths – these are widely criticised as redundant (Law Commission, 2010).
awful lot of people in the system who don’t grasp the significance of proceedings” (lawyer 3).

A further six barristers agreed that training in identifying and engaging with those with mental disorder would be of benefit. More recently qualified barristers emphasised that they were expected to spot such issues, unlike senior colleagues who received cases ‘flagged up’; the climate of criminal solicitors in “factory law firms” delegating client care tasks to counsel was said to make problems more acute for the recently qualified (lawyer 3). One barrister remained concerned that the level of training that could be provided would be necessarily “too superficial” (lawyer 18) to be of use, if it was something busy practitioners had to accommodate in their working lives. Others made suggestions for training to be adapted from that given to new MHRT judges (lawyer 10) or student nurses (lawyer 13).

3.1.2 The relevance of mental disorder

All barristers emphasised that mental disorder needed to be ‘legally relevant’: it had to impact on fitness to plead, a defence, or disposal. There was a spread of opinions on the merit of getting medical reports when something ‘just didn’t feel right’. There was a tension between the view that “the worst thing would be to do a case and have doubts” (lawyer 1) and the practicalities of finite resources, including judicial patience; “judges tend to be very discouraging of raising mental health...unless it’s directly on point...judges will say how could it be admissible and it’s not necessarily always obvious (until you have the report)” (lawyer 18); “judges will say he’s never had a hospital order before, no one else has brought it up” (lawyer 17).

In a very small number of cases, lawyers described being influenced by the tension between legal and clinical best interests in deciding whether to obtain psychiatric reports. In cases involving lower level offending, one barrister described attitudes changing from the view that a short prison sentence was better than the risk of an indefinite hospital order, to a longer-term view that “the right treatment...leads to rehabilitation, preventing them from coming back into the justice system” (lawyer 4), whilst lawyer 8 described trying to counsel an inexperienced colleague out of seeking to run the insanity defence in
an actual bodily harm case. Both lawyers emphasised the importance of engaging in difficult conversations with clients to ensure they were fully informed and understood it was their decision. The two different approaches were interestingly both conceptualised as ultimately being about protecting liberty interests. The fact that such conflicts seemed to occur infrequently in the Crown Court may be due to the often serious nature of the offences defendants faced there: legal and clinical interests may coincide in the choice between prison and hospital.

The ability of psychiatric evidence to present clients’ actions in a different, better light often seemed to tip the balance concerning whether to strongly advocate to a client the need for this evidence. The power of psychiatric reports was seen to be their ability to give an internal account of otherwise bizarre behaviours, and thus render the defendant understandable, if not sympathetic. This theme of needing to use psychiatry to mediate and explicate occurred in virtually all of the interviews:

“You’re thinking of those things constantly: if you have to put someone in front of a jury, you have to think, ‘How they are going to come over? What can I do to mitigate things?’” (lawyer 8);

“Being a criminal lawyer you are going to be interested in psychology, you have put yourself into a person’s shoes, you have to explain it to twelve other people and say ‘you might have done the same’...if the thing is so bizarre...it’s for us to show the sympathetic side, make them more approachable, normalise their behaviour” (lawyer 16).

Sometimes barristers described needing to establish a causal link between the possible disorder and the offending behaviour: lawyer 8 described linking an apparently unprovoked attack on a woman smoking near a baby to the defendant’s post-natal depression which constituted “very, very powerful mitigation” – it effectively allowed a judge to say ‘I see why she did that’. It was not suggested that the mitigation demonstrated that the defendant could not help but act in this way; but that she could not help being ill (and it was suspected that this influenced her actions). This type of reasoning seems to bear out Walker’s argument that the law’s enquiry into the link between illness and action is not truly focussed on a desire to excuse those who were unable to act freely, but the result of a folk psychological desire to have an narrative
explanation for action, rather than a probabilistic one – one needs to be able to say ‘I see why she did it’, not ‘I see why she had to do it’ (Walker, 1985).

3.1.3 Psychiatry within the Law

Barristers regarded psychiatric opinion as part of the evidence to be used in a decision-making process rather than as being definitive of any legal issue; this seems to provide one answer to psychiatrists’ queries about the place of psychiatry within the law (Weissstub, 1978). On the account of those interviewed, psychiatry does not so much inform legal standards and definitions as it does enable lawyers to achieve particular outcomes in selected cases. Psychiatric evidence was something to be introduced to an end, and was capable of challenge and control.

Insofar as fitness to plead was concerned, the chief complaint was that psychiatrists “didn’t know the law” rather than that their approach to the law was uninspiring or unhelpful; only one barrister (who sat as a MHRT Judge) differentiated between those “who don’t know the law...some understand the law but get totally hide-bound by it...the smallest percentage are those who know the law, and know where they are pushing the law and looking for an unorthodox...solution” (lawyer 11). Lawyers did not want to see their function of ‘pleading’ usurped by psychiatrists, and were frustrated by those ‘defence-minded’ psychiatrists who were so partial as to undermine their own credibility. The lawyers interviewed described their practice of narrowly framing the questions they wished psychiatrists to address; the sense of lawyers maintaining a tight control over the phased involvement of psychiatrists was particularly striking in some of lawyer 8’s comments:

“I might go back to a psychiatrist three or four times, a good psychiatrist will not stray into the territory of a psychologist...knows what the remit is of their instructions, they won’t answer the ‘next’ question (i.e. defences or disposal)... a lot of it is the lawyer should be directing the psychiatrist to the areas they want them to cover, and if there are
other issues by all means refer to them, but I’m instructing you for this purpose” (my emphases12).

The question of whether someone was fit to plead was regarded as centring more on the nature of the relationship between client and counsel and the enduring matter of lawyers needing ‘sensible instructions’ to advance a case, rather than turning on psychiatric ideas about individual’s capacity. As Weisstub noted, psychiatry cannot answer normative questions (Weisstub, 1978): it may be thought that the question of at what level of functioning the state can appropriately try a defendant is a normative question, albeit one requiring the expertise of psychiatrists to make individual assessments. Despite both the apparent un-interest of psychiatrists in ‘pushing the law’ in this area and judicial reluctance to countenance such arguments, three barristers described preparing legal arguments that it was “time to review the law” (lawyer 14) and researching legal tests from other jurisdictions which they considered more apposite.

3.1.4 Lawyers ‘pushing the law’ and pushing their instructions

This desire among Crown Court barristers to ‘push’ the law may stem from their first-hand experience of the inequities of the current situation in which someone who is capable of giving instructions based upon their own delusions is said to be fit to plead. They spoke with one voice in being supportive of the putative ‘functional’ test of capacity proposed by the Law Commission (Law Commission, 2010) which focuses on clients’ abilities to give meaningful instructions, and which would lower the threshold of unfitness.

What explains this apparently counter-intuitive desire on the part of barristers to have their clients judged unfit? It may seem obviously unjust to try a very ill defendant as though he were not, but a defendant who is judged unfit to plead will almost certainly still be prosecuted and have even less engagement in a procedure known as a trial of the facts. In such ‘trials’, defence counsel can test the evidence but cannot put a positive case, adduce evidence relevant to mental state, or, in practice, call the defendant. Those

12 All emphases in quotations are the speakers’, unless noted to the contrary.
defendants found to have committed the acts alleged are likely to be made subject to a hospital order.

Yet despite the fact that such defendants would be ‘tried’ in any event, and in a way which heavily circumscribes their involvement\(^\text{13}\), very few of the lawyers seemed to subscribe to Arrigo’s idea that the facilitating the participation of a delusional defendant in a conventional trial was a central part of a lawyer’s role: barristers did not seem to regard greater client participation per se as a victory for autonomy. A slightly different sentiment was expressed by lawyer 13, a former solicitor, who spoke about those adjudged unfit being “completely side-lined” and who thought that an increased understanding of mental illness would lead to “adjustments in the process…it will happen slowly and organically for defendants who have been regarded as unfit to be supported to participate…absolutely essential to have something between a finding of unfitness and a standard trial”.

It is true that if a mentally ill defendant is found fit to plead, a prison sentence becomes a possibility; but for most of the cases which lawyers described as being wrongly excluded from the unfit category (which I will describe as ‘borderline fit’), their illness was so manifest that a hospital order was always the most likely outcome. A theme emerged from the accounts of those barristers who represented borderline fit clients that they felt their involvement in such ‘trials’ was somehow a warping of their true function: “normally, you work with your client to put forward the best case for him or her and because of the Pritchard test (for fitness to plead), you’re prevented from doing that effectively” (lawyer 1).

Most barristers felt themselves under a strong professional obligation to act upon their client’s instructions; an obligation which would be removed if their clients had been judged unfit. Many described trials in which they felt required to put forward delusional instructions as being “a farce” (lawyer 11) and described the curtailment of their ability to give professional advice that was likely to be heeded:

\(^{13}\) One MHRT lawyer commented on the views of those detained after a trial of the facts: ‘there’s a general perception unless you participated, if you didn’t say what you wanted to say, it didn’t happen’ (lawyer 9)
“They don’t have that functional ability to see something from a different perspective, which can be very difficult from a lawyer’s point of view. I knew the last thing he needed was a trial, but I can’t say I know what’s in his best interests” (lawyer 8).

In practical terms, conducting cases which involved a “mental health overlay” (lawyer 1) were acknowledged to involve significant adaptions to the usual client – lawyer relationship. A number of lawyers spoke about the need to change both language and approach to preserve the often fragile rapport, with most lawyers saying that a central problem was overcoming defendants’ feelings of paranoia or mistrust of authority-figures. This work was consistently described as “draining”, “exhausting”, leaving you “shattered”, and some lawyers described themselves as acting “almost like social-workers…‘there, there; dry your eyes’ ” (lawyer 4); social work being something lawyers frequently used against which to define themselves oppositionally. Barristers did not in the main object to having to adapt their working practices to guard against anti-therapeutic consequences (which would in turn affect legal consequences) but were concerned that in such cases they were prevented from being ‘fully’ lawyers.

Twelve of the thirteen barristers broadly concurred that the duty to put a client’s case took precedence over all other considerations, even if that resulted in running the ‘wrong defence’: two lawyers gave examples of borderline fit defendants receiving the mandatory life sentence for murder because the clients would not countenance running diminished responsibility which would have reduced the conviction to manslaughter. Some lawyers discussed the justifications for putting clients’ instructions, including the epistemological uncertainty of knowing what was best for other people: (lawyer 4 on the issue of being instructed not to explore psychiatric avenues which might result in community treatment) “I don’t know which is in their best interests…if your options are you’re homeless, no job, no family, drug problems, prison might be a better life …what one person might think is in their best interests, if you delve a bit deeper, might not be”.

All approached the prospect of putting forward the instructions of the borderline fit with a heavy heart, noting that there was a difference in putting forward the foolish or bizarre instructions of clients who are perfectly well (albeit in other ways disadvantaged), and putting forward the instructions of a client who is or seems to be mentally ill, suggesting that a degree of “paternalism” might be appropriate (lawyer 11). The suggestion that
“with a bit of thought and intelligence, 99 per cent of the time you can square the circle” (lawyer 11) seemed to refer to more than simply trying to explicate the benefits of psychiatric intervention to defendants who rejected it, which all of the lawyers described taking great pains to do. Lawyer 14 most explicitly rejected the idea that he was obliged to put forward delusional instructions. He described seeking to run the right case ‘on the papers’ in cases when clients, whom he had good cause to believe were mentally ill, instructed him to run a case so contrary to the evidence that he considered it unarguable. He spoke about his frustration in one case in which a defendant with post-traumatic stress disorder had written to the Judge, indicating he wanted to enter a guilty plea and did not want the psychiatric involvement he (rightly) believed his lawyers would urge him to accept: “he had taken the matter out of our hands...he didn’t let the system run its course”.

The lawyers who tended to express the deepest regret about putting forward the instructions of borderline fit clients were either among the more senior lawyers in the sample, or had a long experience of working with offenders in their previous professional life. Their engrained bias towards maximising ‘not-prison’ opportunities over facilitating participation may be a function of their greater exposure to the hardness of the prison system, or it may simply be that the stakes are highest in the cases which the most senior barristers are likely to be involved.

These lawyers did not relate their admitted lack of knowledge about mental illness to their ability to distinguish between defendants whose instructions it was and was not safe to act upon, perhaps because many of the defendants about whom they expressed qualms seemed to be gravely ill. For example, it is not clear from the interview whether lawyer 14’s determination that a client with PTSD should not plead guilty when he had an available defence sprung from a belief that PTSD was fundamentally affecting the defendant’s ability to make his own decisions, or whether the issue of the relationship between illness and action did not matter to this lawyer as much as the fact of illness as a possible factor influencing the client’s decision-making. Illness thus created the possibility that this was a client towards whom it might be just to adopt a paternalistic approach – PTSD effectively furnishing this lawyer with an opportunity to run the ‘right defence’ for a man whom he felt very acutely needed his help.
It may be noted from the quotations selected, particularly those referring to the need to mediate between clients and others, that the lawyers themselves often spoke in reported speech. This was notable feature of many of the interviews with both MHRT and Crown Court lawyers; and something put in the margin on many of the transcripts whilst coding was the observation that lawyers would often “switch register/tone”. This was something they often did when asked to describe how they would negotiate difficult situations, such as advising a client who believed they were well to be examined by a psychiatrist, or advising on the disclosure of a largely favourable report which nonetheless had the potential to shatter the client’s personal image of themselves (the latter scenario was particularly common with MHRT lawyers). Lawyers would switch between describing the pros and cons of the situation objectively, adopt the client’s perspective, then address the researcher as the client, often in firm but soothing tones, and then ‘come out’ of the situation and turn to reflecting on how others judging might react.

“‘Oh, are you saying I’m mad?’...‘For this offence it’s common to get a report...we don’t have to use the report if it’s not beneficial to you’, sort of try to bring them around...it would be more beneficial to her than going to court...the court might be able to order a report in due course” (lawyer 4).

It may be thought interesting that both Crown Court and MHRT lawyers adopted a situational approach to discussing complex decision-making: both were obviously interested in talking about a problem from all angles, although it may be that this way of thinking was adopted for different ends in different cases. When barristers discussed doing other than acting on their clients’ instructions, and spoke of using their professional judgement to discern what was in a client’s best interests, this often was reducible to avoiding prison. As this was largely accepted as the end to which all lawyers ought to work, the question of how to arrive at those best interests was conceptualised as a technical legal question about defences and jurisprudence. Understanding the client’s perspective or “tapping into their concerns” (lawyer 8) gave one a better chance at talking the client round to doing the ‘right thing’: the idea of “delving deeper” (lawyer 4) to ensure that the barrister’s idea of the right thing coincided with the client’s priorities was perhaps of subsidiary importance in the binary world of ‘not-prison’ decision making in the Crown Court.
3.2 Perspectives on Decision-making in Mental Health Review Tribunal work

3.2.1 The elusive conflict between clinical and legal interests

It might be thought that MHRT lawyers would experience the paradigmatic conflict, “the incipient tension... (between) psychiatry’s commitment to treatment and the law’s commitment to liberty” (Arrigo, 1996) on a continual basis. This was far from the experience of the five MHRT solicitors who regularly dealt with tribunal hearings, who appeared slightly bemused by the researcher’s insistence upon discussing this theoretical possibility. In those relatively rare cases in which the patient lacks litigation capacity all of the lawyers said that patients without this minimal level of functioning would in practice be unable to care for themselves outside of hospital and that thus their legal and clinical best interests would coincide. Representing very ill patients with capacity who desperately wanted out was “incredibly common” (lawyer 5), and solicitors did not conceptualise this as being about negotiating a conflict between legal and clinical interests, but simply doing their job: “if someone has capacity, I will act on their instructions, even if I think what they want is ridiculous” (lawyer 9).

As with Crown Court lawyers, MHRT lawyers described giving clients realistic advice and “managing expectations” as a central part of their job (lawyer 2): “you go through the criteria with them; ‘you’ve got this diagnosis, and you fulfil the nature and possibly the degree of illness’, and then look at risk and its: ‘you’ve not been tested out, you’ve not been on leave, you’ve not been off the ward, you just changed your name yesterday’ ” (lawyer 5). When dealing with floridly ill clients, for whom “it make take forty-five minutes to get a legal aid form and consent to see medical records signed” (lawyer 9) this process of explanation would be slow and painstaking.

All of the MHRT lawyers unhesitatingly said that at the end of this process they would make an application for immediate discharge if they were so instructed, citing the orthodox legal position that client instructions have to be followed. It may be thought that MHRT lawyers making an application which they feel sure will fail is in fact very unlikely to negatively affect a client’s clinical interests: presumably if the lawyers have made an assessment that the client is not ready for discharge, the treating psychiatrist
would share similar views. However, the way in which the MHRT lawyer decides to make the application can impact upon the client’s legal interests – the hearing can be used to present the patient positively as a future candidate for release, with the lawyer focussing more on converting the doctors rather than convincing the tribunal: “sometimes you’ll go in and think the client is not going to be discharged now but there are lots of issues to address, you can speed up discharge...You’ve got to focus the mind of the doctor, particularly if they have the power to discharge...try to get the doctor to see them as an individual” (lawyer 12).

The dilemma for MHRT lawyers arose when clients with capacity instructed them to act to the detriment of their legal best interests. This is similar to the Crown Court dilemma of representing the borderline fit defendant who will not run ‘the right defence’ – the MHRT lawyers were all personally convinced of the link between the instructions and the illness. Situations like these seemed to arise infrequently in MHRT work, perhaps because the tribunal needs to be sure that the detaining authority has discharged the burden of satisfying the statutory criteria in every case. In theory, this should mean that the representatives can make submissions about the legal criteria irrespective of the patient’s application. However, one important area in which clients instructions can determine hearing outcomes is their attitude to the disclosure of independent psychiatric reports. All of the lawyers were sensitive to the fact that clients did not like having particular diagnostic labels applied to them. Some stated that if a report contained a diagnosis of paranoid schizophrenia some clients would refuse to allow it to be disclosed to the tribunal, notwithstanding the fact that it may also have contained a recommendation that the client should be treated in the community.

In these circumstances, lawyers had little choice but to follow their client’s instructions – in practical terms, disclosing a report would be a more visible departure from instructions than, for example, not cross-examining a witness about alibi evidence. Nonetheless, MHRT lawyers seemed to conceptualise the need to follow their clients’ occasionally self-defeating instructions in more positive terms than Crown Court lawyers: “it’s dangerous for solicitors to go off and think, ‘I’m going to go off on this tangent’ because then the patient wouldn’t have anyone, if even their solicitors were going against what they wanted” (lawyer 2)
The barristers tended to refer to being “stuck with their instructions” – this referred to a situation in which the information presented by a client prevents rather than aids them from achieving a ‘not-prison’ outcome. Following the unhelpful instructions of an ill client seemed to be regarded as something of a necessary evil. It is right to note the different consequences of following a client’s self-defeating instructions in either arena: in the Crown Court, this could be the difference between acquittal and life imprisonment, whereas in the MHRT the most likely scenario was continued detention – although the maintenance of this status quo could obviously result in profoundly detrimental consequences to a client’s well-being.

Some of the language used by one MHRT lawyer to describe her role in ‘being on the client’s side’ seemed to de-centre the element of giving professional advice from the role and re-cast solicitors as intermediaries: “I give time to clients to get their views on detention and if they are happy where they are, so I can put their views across to the independent tribunal to make the decision…it’s the clients hearing and they should be allowed to give their version of events” (lawyer 6). However it was more widely acknowledged that solicitors were there to play a pro-active role, explaining the full scope of possible legal challenges available to the client as well as listening to their immediate concerns: lawyer 6 went on to describe what happened to her clients as a deprivation of liberty and spoke of the need to “fight their corner”; and lawyer 12 described the necessity for probing past client’s initial attitude of contentment - “someone might be perfectly happy but then as soon as a lawyer comes over and says ‘what about this’, you sometimes find that they haven’t been empowered to raise or tackle an issue” (lawyer 12)

3.2.2 Law within Psychiatry

MHRT lawyers were generally positive about their working relationships with psychiatrists but they were not uncritical or deferential in their approach, seemingly viewing psychiatric evidence in no very different light from Crown Court lawyers. Whilst lawyers themselves built up a formidable store of clinical knowledge, they did not aspire to substitute their judgments for those of psychiatrists: “you can get side-tracked into getting too involved in either the medical aspect or the social work aspect...I’m not a doctor, I’m a lawyer. I don’t want doctors telling me about statutory criteria” (lawyer 5).
MHRT lawyers seemed to view their role as a fresh pair of eyes looking over the entirety of the client’s case, and spoke a lot about the need for due process: the tribunal system was a method of “calling doctors and other professionals to account” (lawyer 12). It allowed clients to challenge complacency about their case and resist the sometimes benevolent bureaucracy of those caring for them. Lawyer 12 spoke of persuading a doctor to agree to her client moving to a medium secure hospital, despite the doctor’s concerns that the client would get inferior care and get bored and angry without the programmes available in a high-secure setting: “you can’t keep someone here because of woodwork”.

One MHRT Judge described the results of such bureaucratic tendencies running unchecked:

“You get this great picture of a fractured service split into teams, different professions with different emphases and traditions…a young woman (was) promised treatment ten years ago; no one had refused it, but no one had picked it up” (lawyer 11)

A MHRT lawyer described how such cases were a strong personal impetus for her:

“People get not very good treatment, or not the right treatment, or not enough consistency of treatment or doctors. It’s because the mental system is so appalling that I’m driven to help people assert their rights and receive all the advice they should receive” (lawyer 2)14

A strong anti-bureaucratic tendency ran through many of the transcripts; one Crown Court lawyer described challenging the conclusion of a probation report in similar terms: “you can’t lock him up because he doesn’t work with your groups” and spoke of social workers who wrote unconstructive reports being “wedded to policy…they just heap label after label on someone” (lawyer 8). The relative independence of lawyers and their focus on procedure as a means to an end rather than an end in itself was something particularly valued in the tribunal setting, as lawyers there worked within a psychiatric bureaucracy.

14 Comments like these emerged from questions such as ‘Do you enjoy your job?’ ‘What does it take to be a good lawyer in cases involving an ill client?’
The psychiatric environment of MHRTs (conducted in hospitals) also seemed to sharpen lawyers’ sensibilities to the potential for proceedings to be anti-therapeutic, and in particular the possibility that they might damage the delicate doctor-patient relationship. Their desire to guard against such eventualities seemed to come from an understanding of the domino effect a clinical set-back would have on a client’s prospects of moving on: “if I say something that upsets them, then they could become unwell, they could need medication, and that could go against them in the tribunal” (lawyer 5). MHRT lawyers seemed to view protecting client freedoms as the ultimate end of their involvement as much as Crown Court lawyer’s viewed obtaining ‘not-prison’ as their responsibility; but the former could not adopt ‘not-hospital’ as their ambition without leaving un-protected the several smaller freedoms which mattered to psychiatric patients on their way to discharge or less restrictive accommodation. Being lawyers in a psychiatric setting did not mean that these lawyers adopted therapeutic or clinical values or made assumptions about their clients’ need for treatment. Conversely, they seemed to learn psychiatric language in order to criticise it – lawyer 12 on criticising her client’s treatment pathway - “quite a lot of the time the tribunal will bow out; but it’s my job to say ‘it is a clinical decision, but if it’s not the correct decision, they will be detained at a higher level when they could be lower level or in the community’”.

3.2.3 Time and Money

This type of holistic approach to tribunal work was one which MHRT lawyers and judges spoke of as being under threat because of a tightening of resources. MHRT lawyers all spoke of the need to spend a substantial amount of time with clients, both taking instructions and “digging” to get background information in order to set clients’ accounts into context. It was only through spending this time that lawyers could present apparently ‘hopeless’ cases in a favourable light. Those at the self-employed bar were at a relative remove from financial pressures, other than the vital pressure to turn over enough work to maintain a legal aid practice: many barristers spoke about the mooted re-structuring of their profession as being capable of impinging on their professional judgment and leading to the “sausage-processing” approach to legal aid work taking hold (lawyer 18). Barristers in independent practice are currently insulated from needing for example to
view personal judgments about getting a psychiatric report in the light of the total ‘pot’ of available money in a business. Conversely, MHRT lawyers were acutely aware of the potential impact that every letter, visit or telephone call had on likelihood of their firm’s survival, and there was a tension between the desire to give excellent service and the reality that “I can do work I want to (pro bono), but the department will be gone if you keep writing it off” (lawyer 9).

It seems that as an increasing number of MHRT solicitors work as agents for a number of firms, became consultants or try to develop other areas of practice, firms’ working culture changes. Fewer senior solicitors in-house means that there is “very little supervision for people coming through the rank now…some places will send paralegals out after a week” (lawyer 9), echoing the concern of many lawyers that unqualified people are appearing in cases beyond their competence. Lawyer 12 said she would welcome more advocacy training for lawyers and non-lawyers alike. There was no settled answer as between the MHRT lawyers (or Judges) as to whether the format of the proceedings was adversarial or inquisitorial. The apparent lack of consensus may be no more than different terminologies being employed to mean different things, but the reluctance to describe the system as adversarial and the concomitant indecision about whether or not it is appropriate or obligatory to cross-examine psychiatrists may be symptomatic of a deeper confusion in the profession.

All of the MHRT lawyers were concerned about the possibility that financial disincentives and inadequate training would result in vulnerable clients receiving a sub-standard service: “if you were helping people to sell their house they would be on at you all the time. It’s not like that in mental health work: you could do the bare minimum and not lose any sleep” (lawyer 2). Both of the barristers who sat as MHRT Judges had remarkably similar experiences of seeing poor advocacy performed by unqualified practitioners:

“It’s normally appalling. I think mostly they have no idea at all what they are trying to do. We have a lot of unqualified people. It’s become a magnet for rogue practitioners: they employ paralegals and don’t train them properly. Sometimes they turn up with a check-list of questions…” (lawyer 10)
“Absolutely awful. It’s an absolute scandal to be honest with you... You get people coming down who don’t know the law, people who go through it by rote asking the same questions in every case...It’s a real racket” (lawyer 11)

It was theorised that the poor quality of advocacy in mental health cases may be because advocates are being selective in deciding to which cases to apply themselves properly (Peay, 1989) or that they are trying to subvert the process to ensure that ill people are treated (Warren, 1982). The prosaic but overwhelming impression from this small study seems to be that some of those who appear before MHRTs are poor advocates because they have never been trained as advocates, and that this is part of a broader picture of legal aid cuts and de-professionalization.
3.3 Negotiating Risk

In dealing with hospital orders, and particularly restriction orders\textsuperscript{15}, both Crown Court and MHRT lawyers must engage with the issue of the risk their client may pose. Crown Court Judges have a wide discretion to impose restriction orders on defendants if they consider it necessary to protect the public from the risk of serious harm: the issue for the judge is the likely magnitude of harm, rather than the probability of the harm arising\textsuperscript{16}. Tribunals are required to discharge any person on a hospital or restriction order whom they are not satisfied fulfils the dangerousness criterion that if discharged the patient is likely to act in a manner dangerous to himself or other persons.

In juxtaposing the views and attitudes of Crown Court and MHRT lawyers to risk and to restriction orders one is struck by the pragmatic consensus among both groups of lawyers that “risk is a big deal” (lawyer 5). Whilst setting the boundaries of acceptable risk is still firmly regarded as being a legal concern, risk prediction itself is one of the few areas in which Crown Court lawyers in particular could be said to contemplate ‘deferring’ to psychiatric opinion: an ironic state of affairs given that the legal system removes the ultimate power of discharge from psychiatrists in the most high risk cases. This may not be true deference so much as a signal that at the stage in the proceedings where treatment of one kind or another is under discussion, these lawyers have already achieved their central ‘not-prison’ objective. The other striking feature which emerges from the discussion about risk is the extent to which MHRT and Crown Court lawyers seem to be unfamiliar with the (rather similar) workings of each other’s worlds; and the ability of this dis-connect between criminal and mental health law to result in those who pass through both systems to be treated doubly harshly.

The widespread belief that those experiencing mental illnesses are ‘unpredictable’ and pre-disposed to violence is well documented (Crisp, 2004; Monahan, Steadman, Silver, Appelbaum, Robbins, Mulvey, Roth, Grisso and Banks 2001). However, given the difficulty in raising mental health as an issue in the Crown Court and the substantial

\textsuperscript{15} S41 MHA 1983 – a patient cannot be discharged unless by a tribunal or the Secretary of State, and cannot go on leave or be transferred without Secretary of State’s consent

\textsuperscript{16} R v. Birch
proportion of mentally disordered offenders who end up in prison, universally agreed to be “an aggressive, hostile environment” (lawyer 16), most Crown Court lawyers were content to deal with the association of risk and mental disorder. This association meant that one could secure treatment for a defendant if one could demonstrate that this would reduce risk: “it might be but for that emphasis on risk reduction there would be more punishment” (lawyer 4); “the judge recognised that two psychiatrists were saying if you intervene now, get him medicated and combine it with intensive therapeutic work, you might put him on a different course” (lawyer 8).

A number of lawyers mentioned the particular emphasis on risk in cases involving sexual offences, which some thought was an undue and counter-productive focus, particularly when it involved labelling young men with learning disabilities as ‘sex offenders’. One lawyer said she often tried to get an actuarial assessment of risk in such cases to challenge the knee-jerk reaction of some probation officers. For most Crown Court lawyers, the focus of their endeavours remained on securing ‘not-prison’ outcomes, a task which was made more difficult by the increasing concern among the judiciary that the NHS is unable to deal with dangerous offenders: lawyer 14 described a prosecutor explicitly manipulating this concern, that prosecutor saying in effect: “send them to prison, there’s hospital wings there”. Most lawyers described a concern that a significant minority of judges viewed hospital as a “soft option”, particularly for cases which might provoke “public outrage” (lawyer 7); two were convinced that concerns about risk management by the NHS had influenced juries in rejecting psychiatric defences.

Two barristers seemed to be extremely sceptical about risk predictions generally, and suggested that requiring judicial oversight of clinical decisions was an often unnecessary tactic to diffuse responsibility: “a lot of gubbins is talked these days by psychiatrists and judges about risk...they don’t want blood on their hands” (lawyer 3); “its perception rather than reality...a lot of judges go to restriction orders by default...they don’t want to be on the front page of the Daily Mail for ‘letting someone out’” (lawyer 13). Whilst all of the other barristers expressed in varying degrees the view that restriction orders were a way for judges to share responsibility for ‘difficult cases’ and assuage public concerns, most considered this was inevitable and probably correct. Restriction orders provided a way for judges to order treatment against a background of a lack of faith in NHS staff:
“I’ve heard it said the restriction order isn’t on the defendant, it’s on the doctor...it puts the onus on the doctor to make sure their decisions are correct” (lawyer 1); “it’s so it’s not just a local doctor saying ‘yes, tick’, there are more checks and balances” (lawyer 14); “it’s an additional hurdle so that people aren’t going to be let out in error by doctors who are maybe soft” (lawyer 4).

Most barristers said that they doubted if judges making restriction orders knew that the statutory criteria for release were the same whether or not one was subject to restrictions, and many admitted to being somewhat vague about discharge procedures themselves. Most said that they would be likely to oppose the imposition of a restriction order on the basis of a feeling that it somehow represented a greater deprivation of liberty and was tantamount to a life sentence in a way that a hospital order was not; although one barrister who also sat as a MHRT Judge said that the better care afforded to forensic patients had led her to come round to the view it wasn’t that bad (lawyer 10). This was not a simple acceptance of existing bureaucratic arrangements, but based on her belief that the quality of care for restricted patients could lead to earlier release.

If Crown Court Judges impose restriction orders in order to ensure that an ‘ultra-cautious’ approach is taken with some offenders, their counterpart Crown Court Judges sitting in MHRTs seem to be only too obliging: the MHRT lawyers interviewed concurred that it was a longer road to discharge for most people on restriction orders, and that the need for ‘more intensive care’ for those on such orders could become a self-fulfilling prophecy, as with the doctor reluctant to have their patient moved to medium-secure setting because he has so long had the ‘advantages’ of high-secure treatment (lawyer 12). One MHRT lawyer explicitly said what others hinted at, that the mere fact that someone was on a restriction order operated against them and lead to a more pronounced focus on risk. Four of the five solicitors broadly agreed that this focus in restricted cases was correct, from the statement that “risk to others is paramount in restricted cases, as it should be” (lawyer 6), to a more measured acceptance that “they can be risk averse, but you can understand that” (lawyer 5).

Lawyer 2 believed that the tribunals before which she had appeared had manipulated the criteria to arrive at a decision not to discharge: “I don’t think the legal criteria are applied sufficiently strictly. My gut instinct is that the tribunal go with their gut instinct,
and then try to mould that to the legal criteria” (lawyer 2). Observation and questionnaire-based studies tend to support this suspicion: findings suggest that tribunal decisions are often determined with reference to the pre-hearing assessment of the medical members, and that tribunals will circumvent the law to achieve results they believe to be desirable (Holloway and Grounds, 2003).

The MHRT lawyers were split over the impact that the media had on tribunals, with some saying that a lack of appetite for making robust decisions was more a symptom of being unused to the work rather than a desire “to avoid headlines” (lawyer 12), and others saying that that tribunals become “extra extra cautious” (lawyer 2) after high profile decisions which ‘went wrong’; “a couple of cases impacts massively on everyone else” (lawyer 9). Peay’s concern that defendants who access therapeutic services are treated as defendants rather than patients was echoed by some of the lawyers, lawyer 2 having had a particularly negative experience: “(Judges) treat the tribunal as a criminal court...it’s highly distressing for the client...the first thing he said was ‘Why did you commit this offence?’” (lawyer 2). Salience of risk rather than probability of it occurring still seemed to be the major concern of tribunals dealing with restricted cases, which sometimes led to what was seen as an unduly cautious approach to those whose offences had been “a cry for help” (lawyer 5, talking about arson).

Barring the more profound reservations expressed by lawyer 2, there seemed to be a general feeling that tribunals usually ‘got it right’: one MHRT Judge said that he started work believing he would be the “saviour of all these people, and releasing people right, left and centre, and it hasn’t happened like that...I’m not finding myself in a moral quandary about decisions I’m taking” (lawyer 11). The difficult cases for this lawyer were ones involving community treatment orders; in these cases, he described having to remind other panel members that any degree of compulsion over a patient must still be justified as a deprivation of liberty, and fighting against the attitude that retaining a degree of control could do no harm.

Some lawyers were self-conscious that their own attitude to risk was naturally conservative and described the dilemma they faced in terms of reconciling their instincts towards autonomy and their linked belief in the un-predictability of human behaviour with the perceived high-salience of the risks likely to be posed by many of those they
represented. The phrase “erring on the side of caution” was applied to both decisions to impose restriction orders and decisions not to discharge them. The ascription of risk thus becomes progressively harder to challenge: decision-makers seek for positive evidence of negative risk, suggesting that such defendants may in practice be “doubly disadvantaged” (Peay, 2007).
Chapter 4: Practical Wisdom - A Discussion of Role and Decision-Making

“Trouble, which cuts across roles, takes us to the lowest common denominator of all roles – and that is what we call the person” (Luban, 1988)

4.1 The Conflict of Interests Chimera

The academic concern that those operating at the interface of law and psychiatry may be tempted into adopting each other’s professional values or entering into common-sense compromises was not a concern for the lawyers interviewed in this study. The lawyers interviewed rarely experienced clinical and legal interests as being opposing forces. In the Crown Court, exploring illness could mean generating mitigation and treatment options which were welcome alternatives to prison; but a staged and considered approach to introducing psychiatric evidence was discussed, with an emphasis on ensuring that such evidence was relevant to arriving at a less punitive outcome. A greater cross-fertilisation of knowledge, particularly concerning risk and release regimes, might allow lawyers to make such judgments more reliably. In the MHRTs, evidence of the patient’s clinical needs was viewed as being just that – part of the evidence, which was subject to challenge and contextualisation. MHRT lawyers were alive to the possibility that their efforts to achieve discharge or a less restrictive environment may have unintended detrimental consequences for patients or third parties, but did not strongly identify with these concerns or consider them part of their remit in representing clients in a rigid, risk-averse system.

Equally, decision-making was not rendered more complex by financial pressures, which were viewed as pressures external to the role which impacted on the space available in which to perform it; they did not occlude what the central features of the role were for those already rooted in their professional cultures. The imperative to resist institutional pressures was seen as being something that defined one as a professional: becoming more efficient in response to limited resources was laudable, but to change core working practices, such as spending ‘surplus’ time with ill clients to allow them to ‘ramble’ before attempting to gain their trust, was to be a lawyer no longer. This may be seen as part of lawyers’ sense of themselves as being anti-bureaucratic. One feature of bureaucrats is
their lack of true discretion (Hawkins, 1986): the freedom to exercise professional judgment seemed to be the most jealously guarded privilege of these lawyers, allowing them scope, for example, to fight for a defendant to stay out of prison when the probation service refused to accommodate him in group work because of his youth: “there’s got to be a mechanism for exceptional cases” (lawyer 8).

Lawyers had an understanding that effective advocacy was necessary to perform this anti-bureaucratic role in the context of cases involving clients with mental disorder. Barristers noted that the tone of hearings in which hospital orders were likely to be imposed was less adversarial, but they seemed to adopt “consensual advocacy” (lawyer 3) only in hearings when they were certain to achieve what was defined as ‘a good outcome’; not, for example, in cases where an adversarial approach was necessary to convince a reluctant judge towards treatment. Most regarded a restriction order as a ‘less good outcome’ for the client: it is theorised that lawyers personal conception of how much such an order represents ‘not-prison’ may determine the vigour with which they explore the necessity for the making of such orders.

Those MHRT lawyers interviewed un-confusedly regarded the object of their endeavours as securing freedoms for their client – the difficulty was putting in place those smaller freedoms which could lead to discharge; encouraging analogue decision-making. The power of the responsible clinician was well understood, and all of the lawyers talked about needing to get doctors ‘on-side’ before the hearing:

“You ideally want to resolve all the issues before the tribunal; you can have a good tribunal if you put the ground-work in” (lawyer 9);

“Sometimes I telephone the doctor and say, I’m not working against you: here are the issues” (lawyer 12).

It may be that the reported ineffectiveness of representatives is partly due to the invisibility of this ‘ground-work’ element of the role (Peay, 1989). There was a feeling that advocacy alone would rarely ‘win the day’, although it was seen to have a value in allowing patients some self-expression. The poor advocacy described by the MHRT
Judges seem to be as a result of a lack of training and limited understanding of what a tribunal could be used to achieve even in ‘hopeless cases’.

Bombastic advocacy without ground-work could have deeply counter-productive consequences:

“Some...will love to cause as much trouble as possible. I never do that because if you aren’t going to win the tribunal, the doctor and the client have an on-going relationship and I don’t see the point of creating havoc” (lawyer 9, my emphasis)

It is suggested that decision-making dilemmas were not about the justice of advocating a client’s legal interests as opposed to clinical or other interests: the dilemma was how to identify where legal interests lay. Barristers most frequently encountered such dilemmas; typical occasions involved lawyers being instructed to do things they regarded as self-defeating, such as pleading guilty when a psychiatric defence is available or cross-examining on topics likely to lose them a jury’s sympathy. It might be tempting to characterise barristers’ desire to over-ride their client’s instructions as being an exercise in one-dimensional thinking which does not take into account the particular value of self-expression for mentally disordered clients – and barristers did have a reputation for arrogance among the MHRT lawyers who met them. One barrister thought that men were in particular given to turning client relationships into a “power struggle” (lawyer 8); but how she continues is enlightening:

“You can assert power in different ways...If I can be less confrontational, more humble, more sympathetic and get what I need, that strikes me as being effective”.

Barristers asserting power in client relationships was not viewed as being problematic – the appropriate assertion of power was vital to the task – “a lot of it is about barristers taking control of the decision” (lawyer 3). Whilst barristers recognised the potential for exploitation inherent in this, their primary concern was not that clients might be bullied into a particular course of action but that they might encounter “rubbish barristers who will do the least amount of work”. Such barristers would take the path of least resistance, allowing delusional clients the illusion of exercising decision-making autonomy:
“Only after she was convicted was it pointed out she was autistic, I think she was let down by her defence...it’s easy to call the defendant group ‘other’, ‘they are a bit weird anyway’...or people might think ‘I am being paid this much to do this job’ and...let the chips fall where they may” (lawyer 18)

Good advocates would try to engage and inform the most taxing of clients:

“She (a borderline fit defendant) would say, ‘oh, I think I’ll just plead guilty’ and I would say ‘well, if you want to plead guilty you can, but this is what it means you are accepting: one, two three’; ‘oh I don’t accept that’...we just kept doing that every day” (lawyer 8)

MHRT lawyers gave fewer examples of occasions on which they felt conflicted about identifying where their clients’ legal interests lay: it is suggested that this difference can be understood if one appreciates that the ‘bad outcomes’ of advocating for the immediate discharge of someone within a system designed to maintain a degree of control over patients is different from the ‘bad outcomes’ of advocating delusional instructions in the course of a criminal trial, when the pursuit of those instructions is likely to result in the defendant being consigned to the “dark place” which is prison (lawyer 16). The difference is particularly stark when one considers the greater ability (within their budgets of time and money) possessed by MHRT lawyers to encourage tribunals or doctors to make analogue decisions about patient care alongside their primary submission for discharge. By contrast, the criminal court allows more limited opportunities for counsel to advance their clients’ broad interests: “In court you do or you don’t do –it’s a very exposing place. It was ‘what is your submission? What do you want?’” (lawyer 18).

4.2 The Role of Judgment; ‘Squaring the Circle’ of Disputed Definitions of Justice

In those cases in which determining where a defendant/patient’s legal best interests lie is a complex decision, such as in the scenarios above involve borderline fit clients giving ‘unhelpful’ instructions, lawyers understood the importance of ‘getting inside someone’s head’ – both to gain a better understanding of their situation and to be better able to talk them round to the course of action felt most advisable by the lawyer. The importance of
psychiatric evidence in a case was very much viewed in terms of how well it enabled lawyers to gain this internal understanding of their clients, and how this perspective could be communicated on to juries or judges (or in the case of MHRTs, back to the responsible clinician). It will be observed from the foregoing discussion that lawyers did not think psychiatrists had a uniquely privileged ability to understand clients, and the comment was made that psychiatrists and others working within therapeutic professions could lose sight of the patient/client as a person behind the “label after label” that was applied to them.

Understanding multiple perspectives and being able to explicate one person’s views to another was seen as central to a lawyer’s function. The habit of lawyers in this study to switch personae when describing how they would negotiate a difficult situation may be indicative of their general approach towards decision-making. It may be thought that the necessity for this type of legal explication is all the more acute in cases where client behaviour is particularly extreme or of mysterious origin, particularly if the psychiatric and judicial personnel who deal with such cases are becoming more bureaucratic in outlook; part of the lawyer’s skill was to “make them see the client as an individual”.

All of the lawyers expressed a desire to understand their clients, often connected to the expression of what seemed to be a deep-seated emotional commitment; many talked about the cases which brought sleepless nights, left them raw, exhausted, or took over their lives. However, lawyers were quick to point out that being guided by such emotions alone could be ‘fatal’ for the client’s interests – MHRT lawyers and Judges in particular spoke of a tendency for people to get “over-involved”. Barristers, part of a referral profession, seemed to think that they were generally less likely ‘too close’ to clients: as noted above, their concern was more that some barristers lacked sufficient empathy to deal with ‘difficult’ clients; whether dealing with them involved comprehensively explaining the legal position to such clients, or giving them the opportunity to explain their personal position to their lawyers.

An understanding of what lawyers felt was the right balance between sympathy and detachment is central to their understanding of role – it distinguished them from being friends or social workers (too attached) or from being judges, bureaucrats and the general public (too remote), and made them lawyers:
“It’s about the balance between being patient and sympathetic but not so much that you lose sight of what your role is there to do” (lawyer 8).

Sometimes this professional detachment came unthinkingly:

“He was in hospital for killing his mother, and he apologised to me, and I said (laughs) you know, ‘I’m your solicitor, not anything else!’ You know, ‘that’s fine’ and that was ok, and we took it from there” (lawyer 5)

On other occasions, when what was required was detachment from a vulnerable client who wanted friendship, achieving this distance was difficult.

“I found it very difficult to connect with someone but maintain...to put them in a box. If I connect with someone, I really connect, but to defend someone you have to maintain intellectual distance. But clients want you to be in it with them, 100 per cent” (lawyer 18)

The calibration of the balance of sympathy and detachment has been described as central to the exercise of good judgment, which itself is central to the practice of law:

“To live in the law, rather than off it, is to submit to its discipline and to accept its ideals. Among these ideals is the attainment and exercise of good judgment or practical wisdom...The process of deliberation is curiously bi-focal. Through one lens, the alternatives are seen not merely at close range but actually from within; through the other, all the alternatives are held at an identical distance” (Kronman, 1987).

This description of a lawyer as a possessor and purveyor of ‘practical wisdom’ comes from virtue ethics; an Aristotelian approach to ethics which centres on the character of the actor rather than on the consequences of his actions or his obedience to rules or duties. It has been suggested above that those lawyers who experienced a sense of personal conflict in deciding whether and how to follow client’s (misguided) instructions seemed to be influenced by purposive considerations; how well a lawyer can ‘square the circle’ of advancing a client’s interests towards a not-prison/smaller-freedoms outcome whilst honouring their professional obligation to advance clients’ instructions. Lawyers’ conflicts about acting on the instructions of delusional clients seemed to centre on the
feeling that this situation was a mockery of the purpose of the lawyer-client relationship. The lawyer could not meaningfully advise and the client was not empowered to meaningfully decide in such cases. The difficulty in the context of cases involving clients with disorders is that the sympathy/detachment balance is all the harder to strike; one could see how a surplus of either necessary quality could lead a lawyer to conclude that client does not really understand the advice, when in fact the lawyer does not really understand the client.

The lawyers in this study did not view themselves as being their clients’ “special-purpose friends” (Fried, 1976), required by the adversary system to unquestioningly further their clients’ interests, but instead appreciated the values of detachment as much as attachment. The ability to critically assess what clients want to achieve is maintained if the importance of this equilibrium is acknowledged: it meant that lawyers did not think it was their role to act simply as mouth-pieces for their clients, but felt a responsibility to explain the ramifications of any mooted course of action. The dilemmas experienced by some lawyers in deciding whether and how to follow their clients’ instructions demonstrate awareness that this generally laudable injunction can cause injustice when the clients’ ability to accept or reject advice is compromised.

If this is so, then the quality of lawyers’ decision-making in assessing how to pursue the interests of clients with mental disorder will importantly be related to how well lawyers identify and engage with those affected by such disorders. For all lawyers’ protests that they are not doctors, it is clear that in practice they are called upon to make judgments about whether or not to ‘make an issue’ of fitness or capacity – even when they do not formally raise such matters, the extent to which lawyers felt it necessary to insulate their clients from making wrong decisions varied with whether they felt their client was making a ‘free’ decision e.g. some cases more than others attracted in-depth investigation of whether someone really wanted to plead guilty, or really was happy staying in a high-secure setting.

However, it is equally clear that in making such decisions, lawyers did not imagine that they were making clinical judgments. They conceptualised these conflict of legal interests’ situations as being legal dilemmas about furthering legal best interests – the source of conflict was the disputed definition of legal best interests. Pursuing their
clients’ interests requires technical legal knowledge and effective advocacy: but sympathy and detachment emerge as central to *divining* where those interests lie, and this is at the heart of the interviewed lawyers’ understanding of their broad professional role, as well as their particular role in relation to representing those with mental disorders.
Chapter 5: Conclusions

This study is preceded by an understanding that lawyers’ decision-making is a relatively unexplored field in jurisprudential analyses and clients with mental disorder are a relatively neglected group in the criminological literature; as opposed to (judicial) legal decision-making which has been extensively studied (Gelsthorpe and Padfield, 2003; Kapardis, 1984), as has the link between mental disorder and offending behaviour (Peay, 2007). Further research into the interaction between legal decision-making and clients with mental disorder is necessary: future studies could usefully triangulate these findings with an observational study of cases in Crown Courts and MHRTs supplemented by discussion with clients or with lawyers (given their clients permission).

The study has sought to present lawyers’ perspectives on their decision-making in cases involving clients with mental disorder. Whilst much of the literature written by psychiatrists and jurists might lead one to theorise that lawyers working with mentally ill clients negotiate conflicts between the clinical and legal best interests of those clients, this study seems to suggest that determining clients’ best interests is fundamentally conceptualised as a legal issue. Psychiatric knowledge cannot so much answer this legal problem as provide better routes to framing and understanding it.

The centrality of empathetic understanding to both lawyers’ decision-making and to their self-construction of their role became apparent from the interviews. Crown Court and MHRT lawyers both acknowledged liberty as being the ultimate goal they pursued on behalf of their clients. Appreciating how best to maximise client autonomy and securing it – whether through following or putting aside client instructions, or doing more than asked in terms of fighting for the least restrictive environment – depended upon lawyers’ ability to gauge their clients’ functioning and feelings. This focus on the ability to understand was itself reflective of lawyers conceiving of their role as intercessors, actively mediating relations, rather than intermediaries, relaying information.

Considering that a central concern for Crown Court lawyers was how to advance the interests of the borderline fit client, one might speculate that the adoption of the reformed fitness to plead test mooted by the Law Commission would result in legal conflicts of the
kind described in the study becoming less common. However, it should be remembered that wherever the threshold for fitness to plead is set, the decision to question client capacity and to invoke psychiatric opinions principally rests with defence lawyers. Unless Crown Court lawyers are capable of identifying and engaging with clients with mental disorder, a changed legal test may be to little avail. Equally, whilst resistance to being unduly influenced by financial pressures was a feature of all the interviews, the awareness of tightened resources was universal. The prospect of those less well established in a professional culture bowing to such pressures was something feared by the bar and witnessed by solicitors.

Lawyers’ decision-making and role in relation to clients suffering from mental disorder may be thought to be a particularly acute example of the complexities of legal decision-making in practice. If lawyers’ key skill in furthering their clients’ best interests is their ability to balance sympathy and detachment, they may encounter greater problems both in truly understanding the problems of clients with mental disorder and in mediating those clients’ interactions with judges and juries. Thus, lawyers’ representation of clients with mental disorder may be conceptualised not as an exception to a lawyer’s traditional role but as an exemplar of all that is fundamental to it.
REFERENCES


## Appendix One: Breakdown of Sample Composition

<table>
<thead>
<tr>
<th>Lawyer No.</th>
<th>Professional Background</th>
<th>Years Qualified</th>
<th>Courts</th>
<th>Type/Location of Interview</th>
<th>Gender</th>
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<tbody>
<tr>
<td>1</td>
<td>Barrister</td>
<td>37</td>
<td>Crown Court</td>
<td>In person, in Chambers</td>
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<td>2</td>
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<td>MHRT</td>
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<td>5</td>
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<td>MHRT</td>
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<td>6</td>
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<td>MHRT</td>
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<tr>
<td>10</td>
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<td>20 (as barrister)</td>
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<td>In person, in Chambers</td>
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<tr>
<td>12</td>
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<td>9</td>
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</tr>
<tr>
<td>13</td>
<td>Barrister; former solicitor</td>
<td>9 (as barrister)</td>
<td>Crown Court (MHRTs as solicitor)</td>
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<tr>
<td>JUDGE (Pilot Interview)</td>
<td>Former solicitor</td>
<td>Solicitor (23 years); 10 as Judge</td>
<td>MHRTs; Recorder</td>
<td>In person, in coffee shop</td>
<td>M</td>
</tr>
</tbody>
</table>
Notes:

1. All of the barristers were self-employed and practising in sets of Chambers. Two were Q.C.s. Four of the five solicitors described themselves as consultants rather than in-house solicitors, meaning they were able to work more flexibly e.g., for more than one firm at once.

2. Years of qualification are rounded: for barristers their year of call indicates the date on which they finished their vocational training; some may have spent a few years looking for pupillage, during the first six months of which they would not have rights of audience. For those who qualified as solicitors, all will have spent at least two years completing a training contract before being admitted by the Law Society, and some will have spent years beforehand working as para-legals. Individual employment histories are not detailed in this dissertation to better guarantee the anonymity of participants.