

RISK AND THE MENTAL HEALTH ACT 2007: JEOPARDISING LIBERTY, FACILITATING CONTROL?

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By

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Abstract

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This Ph.D thesis evaluates the impact of the concept of risk on mental health law and policy in England following the introduction of the Mental Health Act 2007, which amended the Mental Health Act 1983. First, the thesis investigates the role played by risk as the principal policy driver of the 2007 Act, arguing that the concept's renewed significance heralds an era of 'New Medicalism' in which the law's determinative power is reduced in order to foster a greater responsiveness to patients' risks. Secondly, it argues that the works of Ulrich Beck and Anthony Giddens, which popularised the 'Risk Society' perspective, and Michel Foucault, who developed the 'Governmentality' thesis, help to illuminate the prevailing trends in mental health policy in the 21st Century. The author contends that Foucault's Governmentality thesis may provide the theoretical foundation on which the concept of risk was deployed by the policy-makers who shaped the 2007 Act. Thirdly, the thesis discusses the reason why risk is such a difficult concept to understand from a legal point of view. It shows that risk-based statutory provisions have the potential to undermine certainty in decision-making processes and notionally make it difficult for patients to predict the nature and extent of their engagement with mental health services. It also demonstrates that risk is a problematic concept for the courts, which have preferred to leave it as a matter of fact. Fourthly, and as a corollary, the thesis hypothesises that because of the greater prominence given to risk there is now more control of, and less liberty for, patients with mental disorder following the introduction of the 2007 Act.

To test this, the author draws upon literature examining the current state of play in mental health practice, the legal oversight of psychiatric decision-making, and the significance of law reform on mental health practice. He finds that in fact the law is rarely determinative of mental health decision-making and that legislative changes do not fundamentally alter the functioning of the compulsory powers. As a result, there is no evidence to suggest that the 2007 Act has jeopardised patients' liberty whilst facilitating greater control over them. For that reason, the final chapter offers a defence of the concept of risk in mental health law. It argues that while the law can never achieve certainty, the concept's inclusion reflects the realities of mental health practice and allows decision-makers to operate according to their training and expertise. This chapter argues that mental health practitioners possess a level of knowledge and understanding of risk which defies objective explication. While mental health policy may be shaped by the desire to control deviance and the law may be drafted to accomplish that end, the reality is that practitioners invariably achieve the 'right' outcome notwithstanding legal and policy uncertainties. The thesis concludes that the 2007 Act has aligned the law with the realities of mental health practice and, for that reason, has not directly jeopardised liberty.

Contents

Abstract	i
Contents	ii
Table of cases	v
Table of legislation	x
Acknowledgements	xvii

INTRODUCTION	1
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PART I: UNDERSTANDING RISK AND THE MENTAL HEALTH ACT 2007

CHAPTER ONE

<i>Background to the Mental Health Act 2007</i>	7
1. Introductory	7
2. A Brief History of Mental Health Law and Policy	8
3. The Rise of the Risk Agenda	19
4. A Battle of Ideas: Mental Health Policy in the 21 st Century	27
5. Much Ado About Nothing? The Mental Health Act 2007	40
6. Conclusions	50

CHAPTER TWO

<i>Risk Perspectives: Finding a Context for the 2007 Act</i>	52
1. Introductory	52
2. Risk Society: Context for the 2007 Act?	54
2.1 The Theories of Ulrich Beck and Anthony Giddens	54
2.2 The Driver of Mental Health Policy? Applying Risk Society	64
2.2.1. The Risk of Developing a Mental Illness	64
2.2.2. The Risk that a Person with Mental Disorder will Cause Harm to Himself or Others	73
3. Governmentality: Plugging a Contextual Gap?	86
3.1 Risk Society <i>versus</i> Governmentality; Realism <i>versus</i> Constructivism	86
3.2 Plugging the Gap: Applying Governmentality to the 2007 Act	92
4. Conclusions	95

CHAPTER THREE

<i>Immediately Befogged: The Problem with Risk</i>	98
1. Introductory	98
2. Is There a General Definition of 'Risk'?	99

3. The Mechanics of Risk	105
3.1. Risk as the Trigger to Compulsion under the MHA	105
3.2. The Deprivation of Liberty Safeguards ('DOLS'): Intensifying the MHA's Focus on Risk	109
3.2.1. The <i>Bournewood</i> Gap	109
3.2.2. The DOLS Framework	113
3.2.3. The Qualifying Requirements: the Interface between the DOLS and the MHA	116
3.3. The Panoply of Risk	122
4. What Does the Case Law Tell Us about Risk?	137
4.1 Getting Our Bearings	137
4.2 The Definition Problem	141
4.2.1. Risk is Not a Legal Term of Art	141
4.2.2. Risk is a Divisible Concept	146
4.3 The Evidential Problem	149
4.3.1. Risk is a Matter of Fact	149
4.3.2. Anything Goes?	152
4.3.3. Procedural Guidance	159
5. The Consequences of Uncertainty: Risk as a Strategic Device?	166
5.1 The Courts' Antipathy to the Creative Use of the MHA	167
5.2 Risk Exceptionalism?	171
6. Conclusions	177

PART II: JEOPARDISING LIBERTY, FACILITATING CONTROL?

CHAPTER FOUR

<i>The Post-2007 Act Era: More Control, Less Liberty?</i>	180
1. Introductory	180
2. The Impact of the 2007 Act	182
2.1. The Statistical Evidence	183
2.1.1. After the 2007 Act: More Admissions, Less Informality	183
2.1.2. The Decrease in the Number of Admissions for Treatment	189
2.1.3. The Impervious Longer-term Trend	195
2.2. The Empirical Evidence	197
2.2.1. How Do Decision-makers Understand and Interpret Risk in Light of the 2007 Act?	199
2.2.2. What Have Been the Consequences of Broadening the MHA's Commitment Criteria?	203
3. Do Reforms to Mental Health Laws Always Achieve their Policy Objectives?	206
3.1. The Evidence	206
3.2. The Verdict	217

4. Does Mental Health Law Always Map Practice?	220
4.1. Getting our Bearings	220
4.2. The Evidence	223
4.2.1. Decision-makers' Knowledge of the Law	225
4.2.2. Decision-makers' Application of the Law	230
4.3. The Verdict	237
5. Conclusions	238
 CHAPTER FIVE	
<i>The Case for New Medicalism: Defending Risk in Mental Health Law</i>	241
1. Introductory	241
2. Realistic and Pragmatic: the Case for New Medicalism	243
2.1. Defining 'New Medicalism'	243
2.2. The Certainty of Uncertainty	247
2.3. The Benefits of Risk	249
2.3.1 Historical Invariance	249
2.3.2 Tailored Responses	252
2.3.3 The Lack of a Credible Alternative	254
2.3.4 Risk and Health	267
2.3.5 The Certainty of Risk	273
2.4. Conclusions	277
3. They Just Know it When They See it: on Tacit Knowledge of Risk	278
3.1. Should there be a Statutory Definition of 'Risk'?	278
3.2. Law is Not the Answer: the Stabilising Influence of Tacit Knowledge	287
4. Conclusions	299
 CONCLUSIONS	302
 Bibliography	309

Table of Cases

<u>A Local Authority v H</u> [2012] EWHC 49 (COP)	115
<u>AB and CB v E and Others</u> [1987] SCLR 419	163
<u>Airedale NHS Trust v Bland</u> [1993] AC 789	110, 258
<u>Alsop v Sheffield City Council</u> [2002] EWCA Civ 429	145
<u>Associated Provincial Picture Houses v Wednesbury Corporation</u> [1947] 1 KB 223	142
<u>B v Croydon Health Authority</u> [1995] Fam 133	171, 271
<u>B v Forsey</u> [1998] SLT 572	139
<u>B v Scottish Ministers</u> [2010] CSIH 31	138, 165
<u>Barker v Barking, Havering and Brentwood Community Healthcare NHS Trust (Warley Hospital)</u> [1999] 1 FLR 106	156
<u>Barnett v Chelsea and Kensington Hospital Management Committee</u> [1969] 1 QB 428	62, 291
<u>Bennetts v Ministry of Defence</u> [2004] EWCA Civ 486	145
<u>Blyth v Birmingham Waterworks Co</u> (1856) 11 Exch. 781	154
<u>Bolam v Friern Hospital Management Committee</u> [1957] 1 WLR 582	63, 150
<u>Bolitho v City and Hackney Health Authority</u> [1997] 4 All ER 771	63, 150, 291
<u>Bolton v Stone</u> [1951] AC 850	165
<u>Bone v Mental Health Review Tribunal</u> [1985] 3 All ER 330, QB	160
<u>Bonnington Castings Limited v Wardlaw</u> [1956] AC 613	153
<u>Brutus v Cozens</u> [1973] AC 854, HL	141, 143
<u>Bryan v Robinson</u> [1960] 2 All ER 173	142
<u>Caparo Industries PLC v Dickman</u> [1990] 2 AC 605	62
<u>CC v KK and Another</u> [2012] EWHC 2136 (COP)	114, 115
<u>Chester West and Cheshire Council v P</u> [2011] EWCA Civ 1257	115
<u>Collins v Wilcock</u> [1984] 3 All ER 374	258
<u>Coombs v Dorset NHS Primary Care Trust</u> [2012] EWHC 521 QB	123
<u>Coombs v Dorset NHS Primary Care Trust</u> [2013] EWCA Civ 471	123
<u>Council of Civil Service Unions v Minister for the Civil Service</u> [1985] AC 374, HL	142, 149
<u>Cullen v North Lanarkshire Council</u> [1998] SC 451	144
<u>DD v Durham County Council</u> [2013] EWCA Civ 96	151
<u>DN v Northumberland Tyne and Wear NHS Foundation Trust</u> [2011] UKUT 327 (AAC)	121
<u>Donoghue v Stevenson</u> [1932] AC 562	62
<u>Dunn v South Tyneside Health Care NHS Trust</u> [2003] EWCA Civ 878	150
<u>G v Central and North West London Mental Health Authority</u> [2007] All ER (D) 286	150
<u>GD v The Hospital Managers of the Edgware Community Hospital</u> [2008] EWHC 3572 (Admin)	169
<u>Glasgow Corporation v Muir</u> [1943] AC 448	154
<u>Gorshkov v Ukraine</u> ECtHR, Application No. 67531/01, Judgment of 8 November 2005	173
<u>Gregg v Scott</u> [2005] UKHL 2	154, 281
<u>Guzzardi v Italy</u> ECtHR, Application No. 7367/76, Judgment of 6 November 1980	173
<u>Hawkes v London Borough of Southwark</u> , 1998 (unreported)	144
<u>Hillingdon London Borough Council v Neary</u> (by his Litigation Friend the Official Solicitor) and Another [2011] EWHC 1377 (COP)	114
<u>HL v United Kingdom</u> (2005) 40 EHRR 32	111, 112, 114
<u>HM v Switzerland</u> (2002) 38 EHRR 314	115
<u>Hotson v East Berkshire Area Health Authority</u> [1987] 2 All ER 909	154, 281
<u>Humphrey v Cady</u> 405 US 504 (1972)	122
<u>In Re Weatherup</u> [2004] NIQB 67	148

<u>J v The Foundation Trust</u> [2009] EWHC 2972 (Fam)	121
<u>JE v DE and Surrey County Council</u> [2006] EWHC 3459 (Fam)	114
<u>Johnson v United Kingdom</u> (1997) 27 EHRR 296	131
<u>Kawka v Poland</u> , ECtHR, Application No. 25874/94, Judgment of 9 January 2001	98
<u>Kokkinakis v Greece</u> ECtHR, Application No. 14307/88, Judgment of 25 May 1993	173
<u>Koonjul v Thameslink Healthcare Services</u> [2000] PIQR 123, CA	144, 146
<u>Latimer v AEC Limited</u> [1953] AC 643	155
<u>LCB v United Kingdom</u> (1999) 27 EHRR 212	147
<u>Lessard v Schmidt</u> 39 F. Supp. 1078 (Ed Wis. 1972)	138
<u>Letting International Limited v Newham London Borough Council</u> [2008] EWHC 1583, QB	145
<u>Lock v Lock</u> [1958] 1 WLR 1248	143
<u>Loveday v Renton</u> [1990] 1 Med LR 117	292
<u>Maynard v West Midlands Regional Health Authority</u> [1985] 1 All ER 635	150
<u>McFarlane v Tayside Health Board</u> [1999] 3 WLR 1301	260
<u>McWilliams v Sir William Arrol and Co Limited</u> [1962] 1 WLR 295	291
<u>MD v Mersey Care NHS Trust</u> [2013] UKUT 127 (AAC)	270
<u>Miller v Jackson</u> [1977] QB 966	165
<u>Miller v Minister of Pensions</u> [1947] 2 All ER 372	153
<u>Morris v West Hartlepool Steam Navigation Company Limited</u> [1956] AC 552	155
<u>Nettleship v Weston</u> [1971] 2 QB 691, CA	154, 289
<u>Nielsen v Denmark</u> (1988) 11 EHRR 175	115
<u>Osman v United Kingdom</u> (2000) 29 EHRR 245	147
<u>Paris v Stepney London Borough Council</u> [1951] AC 367	155
<u>Qualcast (Wolverhampton) v Haynes</u> [1959] AC 743	154
<u>R (on the application of AN) v Mental Health Review Tribunal (Northern Region)</u> [2005] EWCA Civ 1605	153
<u>R (on the application of B) v Ashworth Hospital Authority</u> [2005] UKHL 20 170	131, 142,
<u>R (on the application of B) v S and Others</u> [2006] EWCA Civ 28	108
<u>R (on the application of C) v London South and South West Region</u> Mental Health Review Tribunal [2002] 2 FCR 181	173
<u>R (on the application of DR) v Mersey Care NHS Trust</u> [2002] EWHC 1810 (Admin)	168
<u>R (on the application of East London and the City Mental Health NHS Trust) v</u> Mental Health Review Tribunal [2005] EWHC 2329 (Admin)	161
<u>R (on the application of GP) v Derby City Council</u> [2012] EWHC 1451 (Admin)	158
<u>R (on the application of H) v Ashworth Special Hospital Authority</u> [2002] EWCA Civ 923	156
<u>R (on the application of H) v Mental Health Review Tribunal</u> [2001] EWCA Civ 415	115
<u>R (on the application of H) v Oxfordshire Mental Healthcare NHS Trust</u> [2002] EWHC 465 (Admin)	153
<u>R (on the application of H) v Secretary of State for the Home Department</u> [2003] UKHL 59	173
<u>R (on the application of Huzzey) v Riverside Mental Health Trust</u> (1998) 43 BMLR 167	125
<u>R (on the application of Jones) v Isleworth Crown Court</u> [2005] EWHC 662 (Admin)	159, 160
<u>R (on the application of K) v West London Mental Health Trust</u> [2006] EWCA Civ 118	152
<u>R (on the application of Khela) v Brandon Mental Health Unit</u> [2010] EWHC 3313 (Admin)	150
<u>R (on the application of Li) v Mental Health Review Tribunal</u> [2004] EWHC 51 (Admin)	162
<u>R (on the application of MH) v Secretary of State for Health</u> [2005] UKHL 60	173
<u>R (on the application of MM) v Secretary of State for the Home Department</u> [2007] EWCA Civ 687	155
<u>R (on the application of Munday) v Secretary of State for the Home Department</u>	

[2009] All ER (D) 96 (Admin)	158
<u>R (on the application of Munjaz) v Mersey Care NHS Trust</u> [2006] 2 AC 148	16, 125
<u>R (on the application of O) v Mental Health Review Tribunal</u> [2006] EWHC 2659	170
<u>R (on the application of O) v West London Mental Health NHS Trust</u>	
[2005] EWHC 604 (Admin)	124
<u>R (on the application of OS) v Secretary of State for the Home Department</u>	
[2006] EWHC 1903 (Admin)	158
<u>R (on the application of P) v Secretary of State for Justice</u> [2009] EWCA Civ 701	148
<u>R (on the application of PP) v Secretary of State for Justice</u> [2009] EWHC 2426 (Admin)	147
<u>R (on the application of Pretty) v Director of Public Prosecutions</u>	
<u>(Secretary of State for the Home Department intervening)</u> [2001] UKHL 61	259
<u>R (on the application of Sessay) v South London and Maudsley NHS Foundation Trust</u>	
[2011] EWHC 2617 (QB)	139
<u>R (on the application of Stevens) v Plymouth City Council</u> [2002] EWCA Civ 388	165
<u>R (on the application of the Secretary of State for the Home Department v</u>	
<u>Mental Health Review Tribunal</u> [2003] EWHC 2846 (Admin)	106
<u>R (on the application of the Secretary of State for the Home Department) v</u>	
<u>Mental Health Review Tribunal</u> [2005] EWHC 746 (Admin)	161
<u>R (on the application of Von Brandenburg) v</u>	
<u>East London and the City Mental Health NHS Trust</u> [2004] 2 AC 180	152, 169
<u>R (on the application of W) v Mental Health Review Tribunal</u> [2002] All ER (D) 300 (Apr)	162
<u>R v Ashworth Hospital Authority, ex parte Brady</u> [2000] Lloyd's Rep. Med. 355	255
<u>R v Birch</u> (1990) Cr. App. R. 78	162
<u>R v Bournemouth Community and Mental Health NHS Trust, ex parte L</u> [1999] 1 AC 458;	
<u>R (on the application of L) v Bournemouth Community and Mental Health NHS Trust</u>	
[1998] UKHL 24	17, 49, 109, 111,
122, 139	
<u>R v Canons Park Mental Health Review Tribunal, ex parte A</u> [1994] 2 All ER 659	138
<u>R v Coate</u> (1772) Lofft. 73	17
<u>R v Hallström and Another, ex parte W</u> [1986] QB 1090	167, 168
<u>R v London South and South West Region Mental Health Review Tribunal,</u>	
<u>ex parte Moyle</u> (2000) <i>The Times</i> 10 th February	140, 270
<u>R v Mental Health Review Tribunal for South Thames Region,</u>	
<u>ex parte Smith</u> (1994) 47 BMLR 104	106
<u>R v Mental Health Review Tribunal, ex parte Clatworthy</u> [1985] 2 All ER 699, QB	161, 161
<u>R v Mental Health Review Tribunal, ex parte Pickering</u> [1986] 1 All ER 99	158
<u>R v North West London Mental Health NHS Trust, ex parte Stewart</u> [1997] 4 All ER 871	139, 145
<u>R v North West Thames Mental Health Review Tribunal,</u>	
<u>ex parte Cooper</u> (1990) 5 BMLR 7	151
<u>R v Parole Board, ex party Bradley</u> [1990] 3 All ER 828 (QB)	152, 154
<u>R v Ronald Lonford Golding</u> [2006] EWCA Crim 1965	147
<u>R v Secretary of State for the Home Department</u> [1990] 1 WLR 168	164
<u>R v Secretary of State for the Home Department</u> [1998] 1 WLR 503, CA	125
<u>R v Secretary of State for the Home Department, ex parte Benson,</u>	
9 th November 1988 (unreported)	125
<u>R v Somerset County Council, ex parte Fewings</u> [1995] 1 All ER 513	149
<u>R v Trent Mental Health Review Tribunal, ex parte Ryan</u> [1992] COD 157	159
<u>R v Wilson, ex parte Williamson, Independent</u> , 19 th April 1995, QB	168
<u>Rabone v Pennine Care NHS Foundation Trust</u> [2012] UKSC 2	148
<u>Randall v Randall</u> [1939] P 131	143

<u>Re A (Medical Treatment: Sterilisation)</u> [1999] 53 BMLR 66	110, 118,
255	
<u>Re A, Re C</u> [2010] EWHC 978 (Fam)	115
<u>Re AK (Adult Patient) (Medical Treatment: Consent)</u> [2001] 1 FLR 129	258
<u>Re C (Adult: Refusal of Medical Treatment)</u> [1994] 1 WLR 290	255, 258
<u>Re F (Mental Patient: Sterilisation)</u> [1990] 2 AC 1	110
<u>Re MB (An Adult: Medical Treatment)</u> [1997] 2 FCR 541	255
<u>Re MB (Medical Treatment)</u> [1997] 2 FLR 426	255
<u>Re Officer L</u> [2007] UKHL 36	147
<u>Re S-C (Mental Patient: Habeas Corpus)</u> [1996] QB 599	98
<u>Re T (Adult: Refusal of Treatment)</u> [1992] 3 WLR 782	273
<u>Reeves v Commissioner of Police for the Metropolis</u> [1999] 3 WLR 363	259
<u>Reid v Secretary of State for Scotland</u> [1999] 1 All ER 481	138, 174
<u>Reid v United Kingdom</u> (2003) 37 EHRR 9	174
<u>RH v South London and Maudsley NHS Foundation Trust</u> [2010] EWCA Civ 1273	158
<u>RK (by her Litigation Friend the Official Solicitor v BCC and Others)</u> [2011] EWCA Civ 1305	115
<u>Roe v Ministry of Health</u> [1954] 2 QB 66	155
<u>Saadi v United Kingdom</u> ECtHR Application No. 13229/03, Judgment of 29 January 2008	173
<u>Sabeva v Bulgaria</u> , ECtHR, Application No. 44290/07, Judgment of 10 th June 2010	173
<u>Savage v South Essex Partnership</u>	
<u>NHS Foundation Trust</u> [2008] UKHL 74	122, 147,
148, 151	
<u>Scott v London and St Katherine Docks Co</u> (1865) 3 H&C 596	62
<u>Scott v Wakem</u> (1862) 2 F and F 328	17
<u>Seal v Chief Constable of South Wales Police</u> [2007] UKHL 37	151
<u>Secretary of State for the Home Department v Rehman</u> [2001] UKHL 47	153
<u>Sidaway v Bethlem Royal Hospital Governors</u> [1985] AC 871	63, 150
<u>St George's Healthcare NHS Trust v S</u> [1999] Fam 26, CA	258, 271
<u>Stokes v Cox</u> (1856) 156 ER 1225	145
<u>Stokes v Guest, Keen and Nettlefold (Bolts and Nuts) Limited</u> [1968] 1 WLR 1776	155
<u>Storck v Germany</u> (2005) 43 EHRR 96	115
<u>Surrey County Council v P</u> [2011] EWCA Civ 190	115
<u>Symm v Fraser</u> (1863) 3 F and F 859	17
<u>T v T</u> [1988] 1 All ER 613	110
<u>Tameside and Glossop Acute Services Trust v CH</u> [1996] 1 FCR 753	171, 271
<u>Tarasoff v Regents of University of California</u> 551 P.2d 334 (1967)	165, 260
<u>Trust A v H</u> [2006] 9 CCLR 474	119, 255
<u>United States v Carroll Towing Company</u> 159.F2d 169 (2 nd Cir. 1947)	152
<u>Varbanov v Bulgaria</u> , ECtHR, Application No. 31365/96, Judgment of 5 th October 2000	172
<u>W Primary Care Trust v TB (An Adult by her Litigation Friend the Official Solicitor)</u>	
<u>and Others</u> [2009] EWHC 1731 (Fam.)	157
<u>W v Egdell</u> [1990] Ch 359, CA	164, 260
<u>W v L</u> [1974] QB 711, CA	143
<u>Watt v Hertfordshire County Council</u> [1954] 2 All ER 368	152
<u>Whitehouse v Jordan</u> [1981] 1 All ER 267	63, 150
<u>Whysall v Whysall</u> [1960] P 52	143
<u>Wilsher v Essex Area Health Authority</u> [1987] QB 730	63
<u>Wilsher v Essex Area Health Authority</u> [1988] AC 1074	63, 290
<u>Winterwerp v The Netherlands</u> ,	
ECtHR, Application No. 6301/73, Judgment of 24 th October 1979	171, 172,
173, 175, 176	

<u>Witold Litwa v Poland</u> ECtHR, Application No. 26629/95, Judgment of 4 April 2000	173
<u>X v Finland</u> ECtHR, Application No. 34806/04, Judgment of 3 July 2012	173
<u>X v United Kingdom</u> ECtHR, Application No. 7215/75, Judgment of 5 November 1981	175

Table of Legislation

Act of 1744...9.

County Asylum Act 1808...10.

County Asylum Act 1811...10.

County Asylum Act 1819...10.

Health and Social Care Act 2008...273.

s.129...273.

Lunacy Act 1890...10, 11, 14, 16, 244, 246, 250.

s.4(1)...10.

s.9(1)...10.

s.11(1)...17.

Lunatics Act 1845...10.

Manual Handling Operations Regulations 1992...144.

Reg.4(1)...144.

Reg.4(2)...144.

Matrimonial Causes Act 1937...143.

Matrimonial Causes Act 1950...143.

s.1(1)(d)...143.

Mental Capacity Act 2005...47, 48, 109, 113, 121, 254, 257, 273.

s.1(2)...255.

s.1(4)...257.

s.2(1)...117, 255.

s.3(1)...117, 255.

s.4...118, 255.

s.4(2)...118.

s.4(6)(a)...118.

s.4(6)(b)...118.

s.4(6)(c)...118.

s.4(4)...113.

s.4A...109.

s.4A(1)...113.

s.4A(2)(a)...113.

s.4A(3)...113.

s.4A(5)...113.
s.4B ...113.
s.16(2)(a)...113.
s.21A...121.
Sch.A1...115, 117, 117.
Sch.1A...119, 121.

Mental Deficiency Act 1913...8, 10, 11, 16, 250.

s.1...16.
s.1(c)...18.
s.2...10.

Mental Health Act 1959...8, 12, 13, 16, 38, 39, 230, 231, 244, 246, 248, 250, 299.

s.4...16.
s.4(1)...12.
s.25...12.
s.25(2)(b)...18.
s.25(3)...12.
s.25(4)...12.
s.26...12.
s.26(2)(a)(i)...143.
s.26(2)(b)...18.
s.26(3)...12.
s.33(2)(b)...18.
s.43...12.

Mental Health Act 1983...1, 2, 4, 7, 8, 14, 16, 16, 18, 19, 29, 31, 34, 38, 94, 96, 181, 196, 197, 202, 203, 205, 211, 212, 218, 219, 226, 228, 240, 243, 244, 246, 251, 258, 261, 266, 276, 302, 305.

s.1(2)...2, 15, 32, 117, 182, 241, 255, 280, 302.
s.1(3)...41.
s.2...35, 36, 68, 105, 106, 120, 120, 121, 126, 128, 140, 147, 168, 169, 184, 186, 189, 190, 270, 271.
s.2(2)...105, 257.
s.2(2)(a)...252.
s.2(2)(a)...15.
s.2(2)(b)...15, 107.
s.2(3)...15, 274, 275.
s.2(4)...15, 274.
s.3...36, 43, 68, 105, 114, 120, 120, 121, 126, 140, 147, 148, 153, 162, 167, 168, 169, 184, 186, 189, 190, 191, 192, 193, 207, 217, 226, 257.
s.3(2)...44, 106.
s.3(2)(a)...15, 252.
s.3(2)(b)...2, 15, 32, 41, 106, 182.
s.3(2)(c)...15, 17, 28, 107, 280, 281, 281, 283.
s.3(2)(d)...2, 41, 182, 242, 302.

s.3(3)...15, 274, 275.
s.3(3)(a)...275.
s.3(3)(b)...275.
s.4... 169.
s.4(4)...274.
s.5(2)...274.
s.5(4)...274.
s.5(4)(a)...107.
s.7...26, 75, 270.
s.7(2)(a)...252.
s.7(2)(b)...107.
s.8...26, 75.
s.9...26, 75.
s.10...26, 75.
s.11(1)...48, 105, 274.
s.11(2)...105.
s.11(4)...48, 169.
s.12(1)...275.
s.12(2)...47, 275.
s.12(2A)...47.
s.13...41.
s.17... 167.
s.17(1)...107.
s.17(4)...107.
s.17A...107, 182.
s.17A(2)...43.
s.17A(4)...43.
s.17A(4)(a)...275.
s.17A(4)(b)...275.
s.17A(5)...43.
s.17A(5)(a)...252.
s.17A(6)...2, 44, 76, 123, 123.
s.17B...107, 182.
s.17B(2)(b)...2, 123.
s.17B(2)...44, 76.
s.17B(3)...43.
s.17B(4)...44.
s.17B(5)...44.
s.17B(6)(b)...2.
s.17C...107, 182.
s.17D...107, 182.
s.17D(1)...191.
s.17E...107, 182.
s.17E(1)...44, 123.
s.17E(1)(b)...2, 76, 123.

s.17F...107, 182.
s.17F(4)...44.
s.17G...107, 182.
s.19A...182.
s.20...107, 156, 274, 275.
s.20(1)...15, 106, 274.
s.20(2)...106.
s.20(4)(a)...252.
s.20(7)(a)...252.
s.20A...107, 182.
s.20A(1)...44.
s.20A(3)(a)...44.
s.20A(3)(b)...44.
s.20A(6)(a)...252.
s.20A(7)...2, 76, 123.
s.20B...182.
s.23...274.
s.23(2)(a)...48.
s.25...48, 274.
s.25(1)...125.
s.25A...76.
s.25B...76.
s.25C...76.
s.25D...76.
s.25E...76.
s.25F...76.
s.25G...76.
s.25H...76.
s.25I...76.
s.25J...76.
s.26...105.
s.27...105.
s.28...105.
s.29...105, 168.
s.29(1A)...48.
s.29(2)(za)...48.
s.29(4)(a)...168.
s.30...105.
s.37...139, 155, 159.
s.41... 107, 139, 155, 160.
s.41(1)...2, 123, 159, 162.
s.42...107, 156.
s.43(1)(b)...2, 123.
s.56...167.
s.57...16, 167.

s.58...16, 108, 167.
 s.59...167.
 s.60...167.
 s.62...167.
 s.63...16, 106, 142, 142, 170, 167.
 s.64...167.
 s.66(1)...270.
 s.66(1)(a)...169.
 s.72...107, 169.
 s.72(1)(a)(i)...252.
 s.72(1)(a)(ii)...140.
 s.72(1)(b)...270.
 s.72(1)(b)(i)...252, 270.
 s.72(1)(b)(ii)...140, 270.
 s.72(1)(b)(iia)...270.
 s.72(1)(c)(i)...252.
 s.72(1A)...2, 123.
 s.73(1)(a)...160.
 s.114(1)...46.
 s.114(2)...46.
 s.117...76.
 s.118(1)...125.
 s.118(2A)...47.
 s.118(2B)...47.
 s.118(2B)(i)...250, 253.
 s.130A...47.
 s.130B(1)...47.
 s.130B(2)...48.
 s.130B(3)...48.
 s.130B(4)...48.
 s.130C(2)...48.
 s.131...109.
 s.131(1)...107.
 s.136...107.
 s.139(1)...151.
 s.139(2)...151.
 s.145...46, 123.
 s.145(1)...41, 280.

Mental Health Act 2007...1, 2, 3, 4, 5, 52, 53, 54, 75, 82, 84, 85, 92, 93, 94, 95, 96, 99, 109, 123, 124, 128, 136, 178, 180, 181, 182, 183, 184, 185, 186, 186, 188, 189, 190, 192, 193, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 209, 217, 218, 219, 220, 238, 239, 240, 241, 242, 243, 244, 245, 246, 248, 249, 250, 251, 261, 266, 267, 277, 279, 286, 288, 294, 298, 299, 300, 302, 303, 304, 305, 306, 307.

s.1(2)...2, 40, 94, 182.

s.3...41.
s.4...41, 94, 182.
s.4(2)(b)...106.
s.4(3)...2.
s.7(2)...41.
s.7(3)...41.
s.8...47.
s.9...46, 182.
s.10...46, 182.
s.11...46, 182.
s.12...46, 182.
s.13...46, 182.
s.14...46, 182.
s.15...46, 182.
s.16...46, 182.
s.17...46, 182.
s.18...46.
s.19...46.
s.20...46.
s.21...46.
s.23...48.
s.26...48.
s.30...47.
s.50...48, 109.
s.56...181.
Sch.7...48, 109.
Sch.8...48, 109.
Sch.9...48, 109.
Sch.11...76.

Mental Health Act 2007 (Commencement No.7 and Transitional Provisions) Order 2008...181.
Article 2...181.

Mental Health (Amendment) Act 1982...14.

Mental Health (Approved Clinician) Directions 2008...46.

Mental Health (Approved Mental Health Professionals) (Approval) (England) Regulations 2008...46.

Mental Health (Care and Treatment) (Scotland) Act 2003...263, 266.

s.44(4)...264.
s.44(5)(b)...264.
s.64(4)(a)(i)...264.
s.88(4)(a)...264.
s.88(4)(b)...264.

s.64(5)...264.

Mental Health (Patients in the Community Act) 1995...8, 26, 76.

Mental Health (Scotland) Act 1984...138, 163, 174.

Mental Treatment Act 1930...8, 11, 12, 250.

s.1...11, 18.

s.2...11, 18.

s.3...11, 18.

s.4...11, 18.

s.5...11.

Offences Against the Person Act 1861...155.

s.20...155.

Public Contracts Regulations 2006...145.

Reg.47(6)...145.

Public Health (Control of Disease) Act 1984... 273.

s.45G...273.

Public Order Act 1986...141.

s.5...141.

Statute of the King's Prerogative...9.

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John Bridge Fanning
Liverpool, United Kingdom
29th July 2013

For Mum and Dad

Nil Satis Nisi Optimum

Introduction

The Mental Health Act ('MHA') 1983 is a statutory framework governing the reception, care and treatment of mentally disordered patients.¹ Amongst other things, the MHA provides the legal basis for the compulsory commitment of people who are (i) suffering from a mental disorder of the requisite nature or degree, and (ii) deemed to pose a risk to themselves or other people.² This is one of the most coercive powers at the state's disposal, authorising the detention in a civil context of a person suffering from a mental disorder without proof that he has caused or will cause injury, loss or damage to himself or other people. On 19th July 2007, a Bill to amend the 1983 Act received Royal Assent after a protracted and controversial campaign to reform mental health law. The Mental Health Act 2007 ('2007 Act') became the first statute to affect the mechanics of the MHA's compulsory powers in nearly twenty-five years.

Although it is merely an amending statute, the 2007 Act has notionally made a big impact on mental health law in England and Wales. The government emphasised that the law's priority should be to protect the public from the risks that people with mental disorders can pose.³ It argued that the original 1983 Act's legal prescriptions had 'failed to protect the public [and] patients' and 'undermined public confidence in mental health

¹ Mental Health Act 1983 (hereafter, '1983 Act'), s.1(1).

² 1983 Act, ss.2 and 3.

³ Department of Health, *Reform of the Mental Health Act 1983: Proposals for Consultation*, 1999, The Stationery Office, CM4480, at ch.3, para.4 and ch.5, para.6.

services.⁴ Consequently, a new MHA would seek to regulate patients' risks free from excessive legal prescriptions. First, it would ensure that 'considerations of risk [would] always take precedence' in deciding whether to deploy the compulsory powers.⁵ While there is nothing new about prioritising risk in this way, the 2007 Act is the first mental health statute actually to feature the word 'risk',⁶ suggesting that it has come to serve a more explicit function. Secondly, the new Act would loosen the original 1983 Act's legalism to ensure that decision-makers can respond to patients' risks without being frustrated by legalistic obstacles. Pursuant to this, the 2007 Act has introduced a simpler definition of 'mental disorder'⁷ and abolished the 'treatability' requirement,⁸ thus theoretically making it easier for decision-makers to bring people within the scope of the compulsory powers than was the case under the original 1983 Act.

Risk is central to the 2007 Act's amendments and is the fulcrum on which the compulsory powers turn. Yet, curiously, the MHA neither defines 'risk' nor delimits the concept's scope. Exactly *what* makes a patient a risk for the purposes of the compulsory powers is a matter for decision-makers' discretion.⁹ While the 2007 Act may reflect the

⁴ HM Government, *Reforming the Mental Health Act: Part 1 – The New Legal Framework*, December 2000, Cm 5016-I, at para.2.6.

⁵ *Ibid*, at para.2.16.

⁶ MHA 1983, ss.17A(6); 17B(2)(b); 17E(1)(b); 20A(7); 41(1); 43(1)(b); and 72(1A). These provisions relate to CTOs, restriction orders, and the discharge power of the MHRT.

⁷ MHA 1983, s.1(2) defines 'mental disorder' as 'any disorder or disability of the mind'. This provision was inserted by MHA 2007, s.1(2).

⁸ This appeared formerly under MHA 1983, s.3(2)(b). MHA 2007, s.4(3) inserts the new 'appropriate treatment' requirement into MHA 1983, s.3(2)(d).

⁹ Unless otherwise indicated, the term 'decision-makers' will be used throughout this thesis to refer to the clinicians and approved mental health professionals (AMHPs) who have the authority to apply for, or recommend the use of, the compulsory powers under the MHA. 'Decision-maker' should be construed accordingly.

priorities of the risk policy agenda, a key hypothesis of this project is that this renders mental health decision-making highly discretionary. Coupled with the 2007 Act's 'medicalistic' framework, this means that there may now be little consistency in decision-makers' practices and therefore no certainty for patients facing the prospect of compulsory admission to or continuing detention in hospital.

This thesis investigates whether the 2007 Act has jeopardised patients' liberty and facilitated control by mental health services. It focuses principally on the civil commitment and treatment provisions under Parts II and IV of the amended MHA. This thesis does not discuss patients with mental disorder concerned in criminal proceedings or under sentence for the purposes of Part III of the MHA, although there is no reason why its critique of the concept of risk cannot also apply in this context. The normative ideas of 'jeopardising liberty' and 'facilitating control' are two sides of the same coin; as mental health services' control grows, patients' liberty is more likely to be put in jeopardy. While the terms 'jeopardising liberty' and 'facilitating control' may have sinister undertones, this thesis simply asks whether the effect of the 2007 Act has been to bring more mentally disordered patients within the scope of the compulsory powers and thereby create a presumption of compulsion in mental health practice. It does not seek to argue that the MHA jeopardises liberty or facilitates control more broadly, although some readers may feel that the 2007 Act's amendments make this a possibility.

In answering whether the 2007 Act jeopardises liberty and facilitates control, this thesis will make a number of original contributions to the field of mental health law and policy. First, it will argue that considerations of risk are not new to mental health law. The concept has been an implicit feature of successive legal frameworks dating back centuries. The 2007

Act is therefore the latest in a long line of risk-based mental health legislation; arguments that it heralds an 'age of risk' are therefore misconceived. Secondly, this thesis will posit that the 2007 Act is the product of a distinct philosophical underpinning which we will call 'New Medicalism'. Unlike legalism and 'conventional' medicalism, New Medicalism seeks to lessen the determinative power of mental health law in order specifically to enhance decision-makers' sensitivity and responsiveness to patients' risks. Consequently, we will see that risk has become a *more prominent* feature of mental health law and policy of late. Thirdly, this thesis will employ social theoretical analyses of the concept of risk to illuminate the trends which may have informed contemporary mental health law and policy. Drawing on the work of Ulrich Beck, Anthony Giddens and Michel Foucault, we will see that the emergence of 'risk talk' in mental health policy may be part of a wider process by which the concept has become a defining feature of modern social orders. Fourthly, this project will explore the problem with risk as a technical concept in mental health law. It will show that the absence of a statutory definition of 'risk' and the courts' unwillingness to intervene in the professional domain mean that the concept has the effect of diluting the law's determinative power. This discussion will justify the hypothesis that the 2007 Act jeopardises liberty and facilitates control. In order to test this, we will analyse the commitment statistics and empirical evidence relating to decision-making practices in the post-2007 Act era. The thesis' fifth original contribution will show that while the potential for an increase in the use of the compulsory powers certainly exists following the 2007 Act, in reality there is little essential difference between current decision-making practices and those which prevailed under the original 1983 Act. We will see that amending mental health law is in fact a poor way of giving effect to policy initiatives or mapping decision-making practices. Finally, and as a corollary, this thesis will defend the risk-based New Medicalist

paradigm. In this way it will differ from the prevailing view that the 2007 Act was a disappointing missed opportunity for more radical reform. This thesis will argue that decision-makers simply know a risk when they see one and thus excessive legal supervision is both undesirable and, in any event, impossible. The 2007 Act's New Medicalism implicitly recognises the limits of statutory prescription. Consequently, it merely brings the law into line with pre-existing decision-making practices, which have remained largely unchanged since the amendments were introduced. We will see that although the 2007 Act certainly appears to facilitate control, unchanged decision-making practices have ensured that any increases in the number of people subject to the compulsory powers have nothing to do with amendments to the legal framework. In short, there is no evidence that the 2007 Act jeopardises patients' liberty.

The thesis is divided into five chapters over two parts. The first part is titled 'Understanding Risk and the Mental Health Act 2007' and seeks to establish the parameters of the research by discussing the history and background of the 2007 Act (chapter one), its theoretical context (chapter two) and the doctrinal issues arising from the concept of risk in mental health law (chapter three). Part One aims to show why the question about risk and the 2007 Act's jeopardising liberty and facilitating control is so urgent. Part Two, which is titled 'Jeopardising Liberty, Facilitating Control?', tests the project's hypothesis by evaluating the statistical data and empirical evidence relating to the practice of compulsory decision-making (chapter four). Chapter five then mounts a defence of New Medicalism and the 2007 Act in light of the findings in chapter four, which suggest that reforms to mental health law rarely achieve their policy objectives or map decision-making practices. The final chapter will draw the thesis to a close by setting out its conclusions.

Part One

Understanding Risk and the Mental Health Act 2007

Chapter 1

Background to the Mental Health Act 2007

1. Introductory

The Mental Health Act 2007 ('2007 Act') is the first statute pertaining to the compulsory care and treatment of people with mental disorders since the Mental Health Act 1983 ('1983 Act'). It was the culmination of a decade-long campaign to reform mental health law in England and Wales. Although there were several attempts to introduce a comprehensive new statutory framework during that time, the 2007 Act merely amended the 1983 Act and retained much of the original Mental Health Act's ('MHA') content. The Act's most significant changes reflect the priorities of the risk policy agenda that ultimately won a battle of ideas about the future direction of mental health law. The amended MHA's rationale was therefore to offer decision-makers a framework with which to manage and respond to the risks that people with mental disorders may pose to themselves or others. The concept of risk in this way became a prominent feature of contemporary mental health law and policy.

This chapter explores the background to the 2007 Act in order to offer the reader an insight into the legal and policy context from which the Act emerged. First, it examines the history of mental health law and policy, tracing the roots of the contemporary MHA and the influence of legalism and medicalism in shaping successive legislative frameworks. This discussion aims to shed light on the historical continuity that the 2007 Act represents. Secondly, this chapter charts the rise of the risk policy agenda. It will show that an improving understanding of psychiatry, coupled with growing public concerns about

‘dangerous’ mentally disordered people, propelled the emergence of ‘risk talk’ in mental health policy towards the end of the 20th Century. Thirdly, it evaluates the battle of ideas that forged mental health policy in the early 21st Century. Here, we will see that policy-makers expressly rejected capacity-based and patient-centric alternatives in order to embrace the concept of risk. Finally, we will consider the 2007 Act’s principal amendments and ask whether they warranted the controversy they attracted prior to their introduction. This chapter will conclude that the 2007 Act is a product of a distinct philosophical underpinning which we will call ‘New Medicalism’.

2. A Brief History of Mental Health Law and Policy

According to Gostin, ‘there is perhaps no body of law which has undergone as many fundamental changes in approach and philosophy as mental health law’.¹ It is true that in this area the law is particularly susceptible to change: in the 100 years to 2013 Parliament introduced no fewer than six statutes governing the care and treatment of people with mental disorders.² Each statute reflects the social and political currents extant at the time it was drafted. These trends have had a bearing on whether compulsory psychiatric intervention is seen as coercion or treatment and have shaped the law accordingly.³ The frontier between law and psychiatry is therefore a moveable fixture.

¹ L. Gostin ‘Contemporary Social Historical Perspectives on Mental Health Reform’ (1983) 10(1) *Journal of Law and Society* 47, at p48.

² See the Mental Deficiency Act 1913, Mental Treatment Act 1930, Mental Health Act 1959, Mental Health Act 1983, Mental Health (Patients in the Community) Act 1995, and Mental Health Act 2007.

³ J. Peay, *Decisions and Dilemmas: Working with Mental Health Law*, London: Hart Publishing, 2003, at p139.

It is possible to arrange historical mental health legislation into two categories: 'legalism' and 'medicalism'. 'Legalism' or 'libertarianism'⁴ dictates that patients' detention in hospital ought to be contingent on his satisfying fixed legal criteria. Legalistic statutes have therefore sought to use the law to regulate psychiatry's coercive potential. By contrast, 'medicalism' or 'welfarism'⁵ recasts coercive psychiatric intervention as a legitimate therapeutic strategy and therefore dictates that the law should not interfere unnecessarily in the domain of the medical professionals who use it. There is clearly a tension between legalism and medicalism and the history of mental health law reveals that these oft-competing philosophies have taken turns to inform successive legislative frameworks and the broader policy context.

Laws relating to mental disorders date back to the medieval period.⁶ At that time the law sought to protect landed interests: the Statute of the King's Prerogative, passed during the reign of Edward I, allowed the Crown to assume control of the lands of 'natural fools'.⁷ A single legal code governing the detention of the insane did not emerge until the Act of 1744;⁸ prior to this the mad were subject to a disparate collection of legal powers.⁹ The notion of caring for or treating people suffering from mental illnesses did not inform any of

⁴ J.M. Laing, 'Rights versus Risk? Reform of the Mental Health Act 1983' (2000) 8 *Medical Law Review* 210, at p210.

⁵ Laing, *supra* n.4.

⁶ A passage from the *Laws of Henry I* read: 'Insane persons and evildoers of a like sort should be guarded and treated leniently by their parents.' See also B. Clarke, *Mental Disorder in Earlier Britain*, Cardiff: University of Wales Press, 1975.

⁷ N.W. Walker, *Crime and Insanity in England: Volume 1: The Historical Perspective*, Edinburgh: Edinburgh University Press, 1968, at p25.

⁸ 17 *Geo. II*, c. 5.

⁹ K. Jones, *Lunacy, Law and Conscience 1744-1845: The Social History of the Care of the Insane*, London: Routledge and Keegan Paul, 1955, at pp9-10, 31.

the first statutory regimes. Instead, the emphasis was on creating frameworks by which 'dangerous' people could be removed from the community.¹⁰ There is little doubt that the character of early mental health legislation was 'legalistic', providing a framework of rules to govern patients' confinement as opposed to facilitating clinical interventions. An important characteristic of this brand of legalism was the procedural requirement that judicial gatekeepers should authorise the deployment of the compulsory powers. The Lunacy Act 1890, for example, provided that 'lunatics' could be admitted to an asylum by a 'reception order', which had to be supported by two medical certificates and granted by a 'judicial authority',¹¹ namely a justice of the peace, magistrate or county court judge.¹² Jones argues that the 1890 Act 'bears the heavy impress of the legal mind'.¹³ As Caldicott points out, this early legalism was mostly concerned with avoiding unjust confinement rather than administering care or treatment for mental disorders.¹⁴ The subsequent Mental Deficiency Act 1913 continued in the same vein: it precluded compulsion *unless* there was objectively justifiable evidence that the patient's mental defect had reduced his social functioning and thereby satisfied the threshold requirements under section 2 of the Act.

¹⁰ See, e.g., the County Asylum Acts 1808, 1811 and 1819 and the Lunatics Act 1845, which provided the legal basis for the construction and inspection of lunatic asylums for patients 'dangerous to be at large'.

¹¹ Lunacy Act 1890 ('1890 Act'), s.4(1).

¹² 1890 Act, s.9(1).

¹³ K. Jones, *A History of the Mental Health Services*, London: Routledge and Keegan Paul, 1972, at p181.

¹⁴ F. Caldicott *et al*, 'Client and Clinician: Law as an Intrusion' in N. Eastman and J. Peay (eds.), *Law Without Enforcement: Integrating Mental Health and Justice*, Oxford: Hart Publishing, 1999, at p76. There was even an 'Alleged Lunatics' Friends Society' set up in 1853 to represent the interests of those wrongly confined in asylums.

In the inter-war period, mental health policy departed from legalism. The Royal Commission on Lunacy and Mental Disorder 1924-1926 recommended that treatment should not necessarily be contingent on the type of legalistic certification required by the 1890 and 1913 Acts.¹⁵ The Mental Treatment Act 1930 subsequently introduced new 'voluntary' and 'temporary' patient designations, which reduced the significance of the judicial authority as a gatekeeper to hospital treatment for mental illnesses.¹⁶ This trend continued after the Second World War. Jones argues that three 'revolutions' influenced the direction of mental health policy during this time.¹⁷ First, new drug treatments like chlorpromazine revolutionised mental health services by removing the need for practitioners to detain patients as a matter of course.¹⁸ Secondly, an 'administrative revolution' accelerated a de-institutionalising trend which challenged the primacy of hospital care.¹⁹ Thirdly, a 'legislative revolution' recast mental health law as an 'enabling' device as opposed to a coercive mechanism.²⁰ The Percy Commission recognised that these revolutions had led to 'great advances in medical understanding and methods of treatment of disorders of the mind... [and] great changes in our general social services... [and] in the

¹⁵ See, British Journal of Nursing Editorial, 'Royal Commission on Lunacy and Mental Disorder' (1926) 74 *British Journal of Nursing* 200.

¹⁶ Mental Treatment Act 1930 ('1930 Act'), ss.1-5.

¹⁷ Jones, *supra* n.13, at ch. 11.

¹⁸ *Ibid*, at p292.

¹⁹ *Ibid*, at p294.

²⁰ *Ibid*, at p304.

general attitude towards coercion.’²¹ Its recommendations culminated in the Mental Health Act 1959.

The 1959 Act defined ‘mental disorder’ as ‘mental illness, arrested or incomplete development of mind, psychopathic disorder, and any other disorder or disability of the mind’.²² It extended informal admission by abolishing the 1930 Act’s requirement that a patient had to apply for treatment in hospital of his own free will.²³ Where compulsion was indicated, decision-makers could recommend a patient’s admission for observation²⁴ or treatment.²⁵ ‘Observation orders’ had to be founded on the recommendations of two medical practitioners²⁶ and lasted for twenty-eight days;²⁷ ‘treatment orders’ were subject to the same recommendation requirement²⁸ and were limited to a one-year duration period in the first instance.²⁹ As Jones points out, the 1959 Act’s admission provisions abolished the role of the judicial authority, leaving decisions about compulsion in the hands of professionals.³⁰

²¹ Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 1954-1957, London: Her Majesty’s Stationery Office, Cmnd.169, 1957, at para.65.

²² Mental Health Act 1959 (‘1959 Act’), s.4(1).

²³ 1959 Act, s.5.

²⁴ 1959 Act, s.25.

²⁵ 1959 Act, s.26.

²⁶ 1959 Act, s.25(3).

²⁷ 1959 Act, s.25(4).

²⁸ 1959 Act, s.26(3).

²⁹ 1959 Act, s.43.

³⁰ Jones, *supra* n.13, at p317.

The retreat from legalism was not permanent. In the 1970s, MIND, a mental health charity, launched a campaign to reform mental health law based on Larry Gostin's proposals.³¹ According to Unsworth, Gostin's work translated the growing scepticism of psychiatry into 'a concrete rearmament of patients with stronger legal weaponry to combat the psychiatric power structure'.³² Gostin's work found that clinicians could misuse their powers because the 1959 Act lacked the tight legalistic supervision of previous statutory regimes. He wanted mental health law to prescribe an objective threshold of dangerousness against which decision-makers could measure their patients. His criticism of medicalism in general reveals Gostin's preference for a legalistic alternative:

*The [1959] Act is largely founded upon the judgment of doctors; legal examination has ceased at the barrier of medical expertise, and the liberty of prospective patients is left exclusively under the control of medical judgments which have often been shown in the literature to lack reliability and validity.*³³

To overcome these shortcomings, Gostin argued that the law should insist on reliable and valid admission criteria³⁴ and tackle what he saw were inadequate procedural safeguards.³⁵

³¹ L. Gostin, *A Human Condition: The Mental Health Act from 1959 to 1975 – Observations, Analysis and Proposals for Reform*, London: MIND (National Association for Mental Health), 1975.

³² C. Unsworth, *The Politics of Mental Health Legislation*, Oxford: Clarendon Press, 1987, at p336.

³³ Gostin, *supra* n.31, at p35.

³⁴ Gostin, *supra* n.31, at p42.

³⁵ Gostin, *supra* n.31, at pp35-47. These included the lack of a clear role for social workers in mental health decision-making and the ability of a clinician to act 'tactically' by soliciting an unlimited range of professional opinions until he finds one in agreement with his.

Following a White Paper in 1981,³⁶ the government introduced the Mental Health (Amendment) Act 1982, whose amendments were subsequently consolidated into the 1983 Act. While this Act was a 'reassertion of legalism',³⁷ it was not underpinned by the same policy objectives as the Lunacy Act 1890. Unsworth characterised the 1983 Act as the product of a 'new' legalism which was more 'authentically libertarian'.³⁸ Here, the principal focus of the legislation was the defence of the patient's rights in circumstances where he is apt to lose his liberty.

The 1983 Act introduced four legal categories of mental illness, namely 'mental disorder', 'severe mental impairment', 'mental impairment' and 'psychopathic disorder'.³⁹ To engage the civil commitment powers, decision-makers had to certify the category of mental illness from which the patient was suffering.⁴⁰ The Act provided two grounds for compulsory admission for which either the patient's nearest relative or an approved social worker could apply.⁴¹

First, a patient might be admitted for assessment where (a) he was suffering from mental disorder of a nature or degree which warranted his detention in a hospital for assessment, and (b) he ought to be so detained in the interests of his own health or safety

³⁶ Department of Health and Social Security, *Reform of Mental Health Legislation*, London: Her Majesty's Stationery Office, 1981.

³⁷ Unsworth, *supra* n.32, at p330.

³⁸ Unsworth, *supra* n.32, at p342.

³⁹ 1983 Act, s.1(2).

⁴⁰ The 1983 Act's definition of mental disorder was exclusive. Under s.1(3), a person could not be dealt with under the Act by reason only of promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs.

⁴¹ 1983 Act, s.11(1).

of with a view to the protection of others.⁴² He could be detained on the written recommendations of two registered medical practitioners⁴³ for up to twenty-eight days from the date of his admission.⁴⁴ Secondly, the patient might be admitted for treatment on the grounds that (a) he was suffering from mental illness, severe mental impairment, psychopathic disorder or mental impairment and his mental disorder was of a nature or degree which made it appropriate for him to receive medical treatment in hospital, (b) if he suffered from psychopathic disorder or mental impairment, his condition was treatable, and (c) it was necessary for the health or safety of the patient or for the protection of others that he should receive such treatment.⁴⁵ Admission for treatment had to be founded on the written recommendations of two registered medical practitioners⁴⁶ and could last for up to six months in the first instance, followed by renewal for a further six months and then annually thereafter.⁴⁷ Crucially, the 'treatability' test under section 3(2)(b) prevented decision-makers from using detention as an end in itself. The category of mental disorder in which a patient was placed for the purposes of section 1(2) had a bearing on the nature of his engagement with mental health services. Patients suffering from psychopathic disorder or mental impairment could only be detained if treatment was likely to alleviate or prevent a deterioration of his condition.⁴⁸ There had to be some therapeutic benefit to deploying

⁴² 1983 Act, s.2(2)(a) and (b).

⁴³ 1983 Act, s.2(3).

⁴⁴ 1983 Act, s.2(4).

⁴⁵ 1983 Act, s.3(2)(a)-(c).

⁴⁶ 1983 Act, s.3(3).

⁴⁷ 1983 Act, s.20(1).

⁴⁸ 1983 Act, s.3(2)(b).

the compulsory powers in these cases. Even where the patient was detained under section 3, Part IV of the 1983 Act protected his right to consent to, or request a second opinion for, certain specified treatments.⁴⁹ The 1983 Act's brand of legalism was clearly intended to boost patients' rights.

In spite of a protracted campaign to reform a statute that Lord Steyn once described as 'out of date in its approach',⁵⁰ much of the 1983 Act remains in force today. While the 2007 Act has introduced important amendments (see Part 5 below), the 1983 Act's admission criteria continue to govern who may be subject to compulsory care and treatment. There are two things that we can take from this brief history of mental health law. First, highly changeable social and political factors have always driven mental health policy. The fact that major mental health law reform occurs approximately every quarter of a century indicates that every generation has a different perspective on mental disorder. This is perhaps nowhere more apparent than in the language which features in the statutes. Terms like 'lunacy' and 'feeble-mindedness', or 'idiot' and 'imbecile', which featured in the 1890 and 1913 Acts,⁵¹ are no longer acceptable labels to describe mental disorders or those suffering from them. Indeed, even the term 'subnormality', from the more recent and ostensibly progressive 1959 Act,⁵² seems outmoded by contemporary standards. The care and treatment of people with mental disorders is an area of public policy in which varying

⁴⁹ 1983 Act, ss.57 and 58. Although, for the most part, the patient's consent would not be required where he was subject to the compulsory powers (1983 Act, s.63).

⁵⁰ R (on the application of Munjaz) v Mersey Care NHS Trust [2006] 2 AC 148, at 194.

⁵¹ 1913 Act, s.1.

⁵² 1959 Act, s.4.

attitudes and moral considerations are most keenly felt. It is not surprising that mental health statutes have been so radical and so frequent.

Secondly, mental health law has *always* been concerned with risk. Successive legislative frameworks pertaining to mental disorder have essentially sought to manage the risks patients pose to themselves or other people. While regulating risk may not necessarily have been an *explicit* aim of each piece of legislation, it has always been implied that the law has a protective function in this regard. Although the law's content has grown more sophisticated, the regulation of risk has remained its essential purpose. Indeed, the common law has long accepted that the doctrine of necessity can be invoked to justify the detention of mentally disordered people who pose a danger or potential danger to themselves or others.⁵³ The law has used the perceived threat posed by mentally disordered people to justify the protection of property rights, public morality, and the social order. In recent times, statutes have relied on what might be called a 'risk formula', which refers to the patient's health or safety or the need to protect others, to justify decision-makers' emphasis on risk. In section 11(1) of the 1890 Act, a patient's urgent admission to hospital was permissible where it was expedient 'either for the welfare of a person...or for the public safety'. Sections 2(2)(b) and 3(2)(c) of the 1983 Act refer respectively to the patient being admitted for assessment '*in the interests* of his own health or safety or with a view to the protection of other persons', and a patient being admitted for treatment where it is '*necessary* for the patient's health or safety or for the protection of other persons'.⁵⁴

⁵³ See, e.g., R v Coate (1772) Lofft. 73; Scott v Wakem (1862) 3 F and F 328; Symm v Fraser (1863) 3 F and F 859; and, more recently, R v Bournewood Community and Mental Health NHS Trust, ex parte L [1999] 1 AC 458, HL.

⁵⁴ Emphasis added.

Variations on this 'risk formula' appear in the compulsory assessment, treatment and guardianship powers of successive mental health legislation.⁵⁵ There is therefore nothing new in risk acting as the key to compulsion in mental health law. Put simply, patients who pose a sufficient risk will face detention; those who do not, will not. However, history also tells us that who poses and what constitutes a risk has always been a matter of fact for decision-makers, be they judicial or clinical. The concept is incredibly flexible, potentially applying to a wide range of patients and factors, and thereby engendering a lack of certainty. This thesis does not seek to argue that the concept of risk is a novel feature of mental health law. Yet, after the 1983 Act, risk's influence on mental health policy grew.⁵⁶ In the next part, we evaluate the rise of the risk agenda which would go on to shape the 2007 Act.

⁵⁵ See also, e.g., Mental Deficiency Act 1913, s.1(c), which defined 'feeble-minded persons' as those 'in whose case there exists from birth or from an early age mental defectiveness not amounting to imbecility, yet so pronounced that they require care, supervision and control *for their own protection or for the protection of others...*' (emphasis added); Mental Treatment Act 1930, ss.1-4, which provided that 'voluntary' patients were free to leave hospital by giving seventy-two hours' notice, unless they were incapable of making decisions about their treatment, in which case they could be compelled for their own interests or in the interests of others; Mental Health Act 1959, s.25(2)(b), which made a mentally disordered person's admission for observation contingent on it being 'in the interests of his own health and safety, or with a view to the protection of other persons'; Mental Health Act 1959, s.26(2)(b), which provided that a patient could only be detained in hospital for treatment where it was 'necessary in the interests of his own health and safety, or for the protection of others' that he is so detained; Mental Health Act 1959, s.33(2)(b), which provided that a patient could only be made the subject of guardianship if, *inter alia*, it is necessary in the interests of the patient or for the protection of other persons that the patient should be so received.

⁵⁶ There is an argument that this phenomenon was part of a wider trend whereby risk became a much more prominent feature of health discourse more broadly towards the end of the 20th Century; see, e.g., S. Carter, 'Boundaries of Danger and Uncertainty: an Analysis of the Technological Culture of Risk Assessment' in J. Gabe (ed.) *Medicine, Health and Risk: Sociological Approaches*, Oxford: Blackwell Publishers Limited, 1995.

3. The Rise of the Risk Agenda: 1983-2000

Risk became a prominent feature of mental health policy during the 1990s principally for two reasons: (i) psychiatry developed a better understanding of the predictive value of certain risk factors, and (ii) growing public anxiety that mental health services were not doing enough to tackle 'risky' behaviour.

First, knowledge of the factors that might lead a person with mental disorder to harm himself or others developed enormously in the late 20th Century. Prior to the 1983 Act, psychiatrists doubted that they could predict the likelihood of such adverse outcomes.⁵⁷ Cocozza and Steadman argued that even with a definition of 'dangerousness' and empirical evidence suggesting that mentally disordered people are riskier than the general population, the task of predicting harmful outcomes would still be 'formidable'.⁵⁸ Only short-term clinical predictions were considered accurate to any significant degree, and only then when the prediction and the outcome were proximate in time and space.⁵⁹ Commentators invariably argued that the task of predicting patients' future dangerousness is simply too subjective.⁶⁰ Diamond was even more candid: any studies which suggested that

⁵⁷ See, e.g., J. Monahan, *The Clinical Prediction of Violence Behavior*, Washington DC: US Government Printing Office, 1981; P.E. Mullen, 'Mental Disorder and Dangerousness' (1984) 18 *Australian and New Zealand Journal of Psychiatry* 8.

⁵⁸ J. Cocozza and H. Steadman, 'The Failure of Psychiatric Predictions of Dangerousness: Clear and Convincing Evidence' (1976) 29 *Rutgers Law Review* 1084, at p1091.

⁵⁹ E.R. Rofman *et al*, 'The Prediction of Dangerous Behaviour in Emergency Civil Commitment' (1980) 137 *American Journal of Psychiatry* 1061, at p1063.

⁶⁰ H. Birns and J.S. Levien, 'Dangerousness: Legal Determinations and Clinical Speculations' (1980) 52(2) *Psychiatric Quarterly* 108, at p115. Birns and Levien argued that the only way to counteract this problem would be for the courts to require evidence of 'specific violent or harmful acts, including the imminence and frequency of such acts and the magnitude of harm occasioned by them...'

psychiatrists could predict the occurrence of dangerous behaviour among mentally disordered patients were 'pseudo-scientific'.⁶¹ In the 1960s and 1970s, there had also been a body of anti-psychiatry literature, which doubted the existence of mental disorder at all. Perhaps the most well-known proponent of this view is Thomas Szasz, who argued that mental illness is a social construct designed to justify the coercion of people exhibiting aberrant behaviour.⁶² While policy-makers were always unlikely to adopt anti-psychiatry as a guiding principle,⁶³ Glover-Thomas implies that Szasz's theories played a part in the revival of legalism in the 1980s.⁶⁴ In any event, scepticism of psychiatry's ability to predict adverse outcomes gave way to grudging acceptance that some risk factors pertaining to the patient's condition or circumstances may make them more likely.⁶⁵ In particular, Monahan concluded, albeit reluctantly, that the relationship between mental disorder and violent

⁶¹ B.L. Diamond, 'The Psychiatric Prediction of Dangerousness' (1974) 123 *University of Pennsylvania Law Review* 75, at pp443, 452.

⁶² See, e.g., T. Szasz, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*, New York: Hoeber-Harper, 1961; T. Szasz, *The Manufacture of Madness: a Comparative Study of the Inquisition and the Mental Health Movement*, New York: Harper and Row, 1970. See also, T. Szasz, *Coercion as Cure: A Critical History of Psychiatry* London: Transaction, 2007; T. Szasz, 'Mental Illness: Psychiatry's Phlogiston' (2001) 27 *Journal of Medical Ethics* 297; T. Szasz, 'Psychiatry and the Control of Dangerousness: the Apotropaic Function of the Term "Mental Illness"' (2003) 29 *Journal of Medical Ethics* 227. For counterblasts to Szasz, see M.S. Moore, 'Some Myths about "Mental Illness"' (1975) 32 *Archives of General Psychiatry* 1483 and R. Pies, 'On Myths and Countermyths' (1979) 36 *Archives of General Psychiatry* 139.

⁶³ It seems that the main reason for this is anti-psychiatry's failure to propose an alternative framework for the care of people who, if not adjudged 'insane', would still be deemed 'maladjusted' in some way and therefore needful of the same type care or treatment afforded to the mentally ill; see, e.g., P. Bean, *Compulsory Admission to Mental Hospitals*, Chichester: John Wiley & Sons Limited, 1980, at pp201-2.

⁶⁴ N. Glover-Thomas, *Reconstructing Mental Health Law and Policy*, London: LexisNexis Butterworths Tolley, 2002, at p31.

⁶⁵ J. Monahan, 'Mental Disorder and Violent Behaviour' (1992) 47(4) *American Psychologist* 511; B.G. Link and A. Stueve, 'Psychotic Symptoms and the Violent/Illegal Behaviour of Mental Patients Compared to Community Controls' in J. Monahan *et al* (eds.) Violence and Mental Disorder: Developments in Risk Assessment, Chicago: University of Chicago Press, 1994.

behaviour 'cannot be fobbed off as chance or explained away by other factors'.⁶⁶ Indeed, he noted that although it may be a myth that violence is a likely corollary of mental disorder, 'it may still be worth noting that it is a myth that is both culturally universal and historically invariant'.⁶⁷ Monahan found that whether the measure was the prevalence of violence among the disordered, or the prevalence of disorder among the violent, mental disorder may be a 'robust and significant' factor.⁶⁸

Subsequent studies confirmed that clinical factors carry a high predictive value.⁶⁹ Patients with psychopathy,⁷⁰ affective disorders,⁷¹ schizophrenia,⁷² and so-called 'threat/control-override' symptoms⁷³ were found to be more likely to pose a risk to themselves or other people. Other studies found that *non-clinical* demographic factors like gender,⁷⁴ age,⁷⁵ and socio-economic background and circumstances,⁷⁶ may also be pertinent

⁶⁶ *Ibid*, at p511.

⁶⁷ *Ibid*, at p513.

⁶⁸ *Ibid*, at p519.

⁶⁹ See, e.g., A.M. Rossi *et al*, 'Characteristics of Psychiatric Patients who Engage in Assaultive or Other Fear-inducing Behaviours' (1986) 174(3) *The Journal of Nervous and Mental Disease* 154. Rossi *et al* found that clinical variables tended to have a more consistent relationship to violent behaviour than demographic variables.

⁷⁰ R.D. Hare, 'Psychopathy and Risk for Recidivism and Violence' in N. Gray *et al* (eds.) Criminal Justice, Mental Health and the Politics of Risk, London: Cavendish Publishing Ltd, 2002.

⁷¹ M.G. Kennedy, 'Relationship Between Psychiatric Diagnosis and Patient Aggression' (1993) 14(3) *Issues in Mental Health Nursing* 263.

⁷² J.W. Swanson *et al*, 'A National Study of Violent Behaviour in Persons with Schizophrenia' (2006) 63 *Archives of General Psychiatry* 490.

⁷³ J.W. Swanson *et al*, 'Psychotic Symptoms and Disorders and the Risk of Violent Behaviour in the Community' (1996) 6(4) *Criminal Behaviour and Mental Health* 309.

⁷⁴ E. Silver *et al*, 'Assessing Violence Risk Among Discharged Psychiatric Patients: Towards an Ecological Approach' (1999) 23(2) *Law and Human Behaviour* 237.

to risk. Statistics showed that people with mental disorder who consumed alcohol or illicit substances were more likely to pose a threat to themselves or others,⁷⁷ while variables like homelessness and co-present mood and post-traumatic stress disorders were also thought to increase the likelihood of violent behaviour among patients.⁷⁸ This confluence of clinical and non-clinical indicators led Hiday to argue that social factors must intervene before a patient with mental disorder will perpetrate violence.⁷⁹ Clinicians' professional bodies also began to recognise the importance of risk in psychiatric assessments. By Article 4 of its Declaration of Madrid in 1996, the World Psychiatric Association stated:

*No treatment should be provided against the patient's will, **unless withholding treatment would endanger the life of the patient and/or the life of others.** Treatment must always be in the best interests of the patient.*⁸⁰

⁷⁵ J. Swanson *et al*, 'Violent Behaviour Preceding Hospitalisation Among Persons with Severe Mental Illness' (1999) 23(2) *Law and Human Behaviour* 185.

⁷⁶ N. Rose, 'Governing Risky Individuals: the Role of Psychiatry in New Regimes of Control' (1999) 5(2) *Psychiatry, Psychology and Law* 177.

⁷⁷ B.J. Cuffel *et al*, 'A Longitudinal Study of Substance Use and Community Violence in Schizophrenia' (1994) 182(12) *Journal of Nervous and Mental Disease* 704; M. Soyka, 'Substance Misuse, Psychiatric Disorder and Violent and Disturbed Behaviour' (2000) 176 *British Journal of Psychiatry* 345; H.J. Steadman *et al*, 'Violence by People Discharged from Acute Psychiatric Inpatient Facilities and by Others in the Same Neighbourhoods' (1988) 55 *Archives of General Psychiatry* 393; S. Wright *et al* 'Mental Illness, Substance Abuse, Demographics and Offending: Dual Diagnosis in the Suburbs' (2002) 13(1) *Journal of Forensic Psychiatry* 35.

⁷⁸ J. W. Swanson *et al*, 'The Social-Environmental Context of Violent Behaviour in Persons Treated for Severe Mental Illness' (2002) 92(9) *American Journal of Public Health* 1523.

⁷⁹ V.A. Hiday, 'The Social Context of Mental Illness and Violence' (1995) 36(2) *Journal of Health and Social Behaviour* 122, at p130.

⁸⁰ Article 4 of the Declaration of Madrid, World Psychiatric Association 1996. Emphasis added.

The Declaration is clear evidence that psychiatrists had come to regard compulsory treatment of mental disorder as contingent on a finding of fact about patients' consent or risk.

The development of medical understanding and knowledge of risk factors had made it possible for clinicians to identify what issues might lead their patients to crisis. As a consequence, a person's 'dangerousness' was no longer extrinsic and unknowable. This presented a new opportunity to mental health practitioners by allowing them to take decisions with reference to statistical evidence rather than using unreliable clinical judgements.⁸¹ Writing in 1980, Steadman found that statistical prediction of adverse outcomes is superior to clinical methods because it is more accurate and less error-prone.⁸² By the mid-1990s, there was a growing recognition that actuarial tools had some utility when assessing patients' risks.⁸³ This was part of a broader trend towards actuarial justice which emerged in other fields around the same time.⁸⁴ Actuarial tools measure a patient

⁸¹ There is a long-held belief in mental health practice that actuarial tools can achieve more reliable results than unaided clinical judgement; see, e.g., H.W. Dunham and B.N. Meltzer, 'Predicting Length of Hospitalisation of Mental Patients' (1946) 52(2) *American Journal of Sociology* 123, at p131. There is a wealth of literature dating back decades which questions the accuracy and reliability of clinical judgement; see, e.g., P.J. Hoffman, 'The Paramorphic Representation of Clinical Judgement' (1960) 57(2) *Psychological Bulletin* 116; L.R. Goldberg, 'Simple Models or Simple Processes? Some Research on Clinical Judgements' (1968) 23 *American Psychologist* 483; P.D. Werner *et al*, 'Reliability, Accuracy and Decision-making Strategy in Clinical Predictions of Imminent Dangerousness' (1983) 51(6) *Journal of Consulting and Clinical Psychology* 815; J. Gunn and J. Monahan, 'Dangerousness' in J. Gunn and P.J. Taylor (eds.) *Forensic Psychiatry: Clinical, Legal and Ethical Issues*, Oxford: Butterworth-Heinemann, 1993, at p628.

⁸² H.J. Steadman, 'The Right Not to be a False Positive: Problems in the Application of the Dangerousness Standard' (1980) 52(2) *Psychiatric Quarterly* 84, at p95.

⁸³ See, e.g., D.E. McNeil and R.L. Binder, 'Screening for Risk of Inpatient Violence: Validation of an Actuarial Tool' (1994) 18(5) *Law and Human Behaviour* 579.

⁸⁴ See, e.g., M. M. Feeley and J. Simon, 'The New Penology: Notes on the Emerging Strategy of Corrections and its Implications' (1992) 30(4) *Criminology* 449; M. Feeley and J. Simon, 'Actuarial Justice: the Emerging New Criminal Law' in D. Nelken (ed.), *The Futures of Criminology*, London: Sage Publications Limited, 1994.

against a statistical norm; if he deviates from it then he is more likely to pose a risk than the patient who adheres to it. By measuring patients against a pre-determined standard in this way, such tools transform mental health decision-making into a purportedly scientific process. In more recent years, there is evidence that actuarial assessments achieve 'statistically superior accuracy' than standard clinical approaches.⁸⁵ They have also been refined so that their processes are more readily tailored to the patient, e.g., the Iterative Classification Tree (ICT) method depends on the answers given to each prior question.⁸⁶ The development of these techniques has both encouraged and reflected the improvements in psychiatric understanding of risk.

Yet, it would be false to suggest that psychiatrists' new-found enthusiasm for actuarial techniques was unanimous. Scepticism endured as some studies cast doubt on the predictive value of clinical factors like the presence of delusions,⁸⁷ and non-clinical factors like the impact of alcohol and drug use.⁸⁸ For every study that reported increases in predictive accuracy there was another that found the accuracy of actuarial assessments to be still no better than chance.⁸⁹ While Steadman thought that the misuse of illicit drugs increased the risk of violence, he found no evidence to suggest that people with mental

⁸⁵ M.A. Norko and M.V. Baranoski, 'The State of Contemporary Risk Assessment Research' (2005) 50(1) *Canadian Journal of Psychiatry* 18, at pp23-4.

⁸⁶ J. Monahan *et al*, 'An Actuarial Model of Violence Risk Assessment for Persons with Mental Disorders' (2005) 56(7) *Psychiatric Services* 810; J. Monahan *et al*, 'Developing a Clinically Useful Actuarial Tool for Assessing Violence Risk' (2000) 176 *British Journal of Psychiatry* 312.

⁸⁷ P.S. Appelbaum *et al*, 'Violence and Delusions: Data from the MacArthur Violence Risk Assessment Study' (2000) 157(4) *American Journal of Psychiatry* 566.

⁸⁸ See, e.g., N. Hodelet, 'Psychosis and Offending in British Columbia: Characteristics of a Secure Hospital Population' (2001) 11(3) *Criminal Behaviour and Mental Health* 163.

⁸⁹ J. Monahan, 'Risk Assessment of Violence among the Mentally Disordered: Generating Useful Knowledge' (1988) 11 *International Journal of Law and Psychiatry* 249, at p251.

illness are more likely to act violently than anyone else in the community.⁹⁰ More fundamentally, Gunn argued that while statistics can be a powerful way to predict group activities, this macro-level accuracy is useless when it comes to predicting individual behaviour.⁹¹ Dawes *et al* referred to the 'broken leg' problem: while actuarial formulae might predict one outcome with a high degree of accuracy, e.g., that a person goes to the cinema once a week, they are useless if that person breaks his leg and therefore cannot follow his normal routine.⁹² In other words, actuarial approaches do nothing to explain the *causes* of an *individual* patient's disorder and risks,⁹³ and assume a high degree of probability which is not necessarily reflected in reality. As Buchanan pointed out, 'explanations of human behaviour rarely show that an act was inevitable or even highly probable'.⁹⁴ For that reason, there are no prediction tables that will tell us with any certainty who can be released with little risk to others; in Walker's view this meant that clinical judgement must remain the primary basis for recommendations under the MHA.⁹⁵ For the sceptics, then, risk factors play a key role in providing an overall picture of the patient's condition, but they cannot be a guarantee of what will actually happen. Decision-

⁹⁰ Steadman, *supra* n.77. See also, E.B. Elbogen and S.C. Johnson, 'The Intricate Link between Violence and Mental Disorder' (2009) 66(2) *Archives of General Psychiatry* 152.

⁹¹ J. Gunn, 'The Management and Discharge of Violent Patients' in N. Walker (ed.) *Dangerous People*, Blackstone Press, 1996, at p119.

⁹² R.M. Dawes *et al*, 'Clinical versus Actuarial Judgement' (1989) 243 *Science* 1668, at p1670. It is worth pointing out that Dawes *et al* were generally supportive of actuarial techniques as a supplement to clinical judgement; see p1673. On the 'broken leg' problem, see also P.E. Meehl, *Clinical versus Statistical Prediction: a Theoretical Analysis and a Review of the Evidence*, Minneapolis: University of Minnesota Press, 1954, at chapter 4.

⁹³ G.T. Harris and M.E. Rice, 'Risk Appraisal and Management of Violent Behaviour' (1997) 48(9) *Psychiatric Services* 1168, at p1173.

⁹⁴ A. Buchanan, 'Risk and Dangerousness' (1999) 29(2) *Psychological Medicine* 465, at p469.

⁹⁵ N. Walker, 'Dangerous Mistakes' (1991) 158(6) *British Journal of Psychiatry* 752, at p757.

making based on objective factors is therefore about as reliable as weather forecasting.⁹⁶

Nonetheless, despite this criticism, psychiatry's presumed ability to reduce or extinguish risk would ultimately inform the policy behind the 2007 Act.

The second reason why the risk agenda gained traction was the vociferous public demand for tougher measures to counter the perceived threat posed by people with mental disorders. This was a direct consequence of the emergence of risk-based decision-making. The fact that decision-makers could predict the likelihood of adverse outcomes challenged the paradigm of institutionalised care. The law already authorised de-institutionalised care in the form of guardianship⁹⁷ and leave,⁹⁸ but, during the 1990s, government policy put a renewed emphasis on community-based strategies.⁹⁹ As a result, mentally disordered people were more visible in the community.

High profile homicides committed by people with mental illness reinforced the public's impression that they are inherently dangerous.¹⁰⁰ At a time when mental health practitioners felt more able to co-ordinate their patients' treatment outside hospital, a media frenzy questioned whether these killings showed that care in the community was

⁹⁶ H.P. Morgan, 'Management of Suicide Risk' (1997) 21(4) *Psychiatric Bulletin* 214, at p214.

⁹⁷ 1983 Act, ss.7-10.

⁹⁸ 1983 Act, s.17.

⁹⁹ See, e.g., the Mental Health (Patients in the Community) Act 1995, which established after care under supervision.

¹⁰⁰ The murder of Jonathan Zito in 1992 and the vicious attack on the Russell family in 1996 are the most well-known cases from this period. The crimes were committed by a man with schizophrenia and a man with personality disorder respectively. The Zito case led to calls for tougher mental health laws; see, e.g., BBC News, *Call to Tighten Mental Health Laws* 18th February 1998, available at <http://news.bbc.co.uk/1/hi/uk/57659.stm>. Accessed 24th September 2010.

misconceived.¹⁰¹ The potentially corrosive impact that the media can have on public attitudes to mental disorder is not a new phenomenon. Writing in 1966, Scheff argued that newspapers establish an ‘ineluctable relationship’ between mental disorder and violent and unpredictable acts.¹⁰² In the 1990s, mental health captured the public imagination once again. It is ironic that the public demanded that clinicians do more to monitor patients’ risks at a time when risk-based decision-making allowed mentally disordered people to live in the community. Nonetheless, by the early 2000s, policy-makers began to reap political dividends by pursuing populist mental health policies in response to public concerns.¹⁰³ The stage was set for a battle of ideas over the future of mental health law.

4. A Battle of Ideas: Mental Health Policy in the 21st Century

In 1998, the Department of Health appointed an expert committee to advise the government on reforming the MHA. The Richardson Committee proposed rooting a new MHA in the principles of patient autonomy and non-discrimination.¹⁰⁴ It also recommended that future legislation follow a predominantly legalistic framework: ‘Deprivations of liberty must be expressly provided for... or necessarily implied for the purposes of achieving a

¹⁰¹ See, e.g., Daily Mail, *Freed to Kill in the Community*, Friday, 2nd July 1993, at p30; Daily Mirror, *Failed: Scandal of Schizophrenics Freed to Kill...*, Tuesday, 26th September 1995, at p5.

¹⁰² T.J. Scheff, *Being Mentally Ill: A Sociological Theory*, Chicago: Aldine Atherton, 1966, at p73; see also H.J. Steadman and J.J. Cocozza, ‘Selective Reporting and the Public’s Misconception of the Criminally Insane’ (1978) 41(4) *The Public Opinion Quarterly* 523.

¹⁰³ On the political significance of populist mental health policies, see M. Petrunik, ‘The Politics of Dangerousness’ (1982) 5(3-2) *International Journal of Law and Psychiatry* 225.

¹⁰⁴ Department of Health, *Report of the Expert Committee: Review of the Mental Health Act 1983*, November 1999 (hereafter, ‘Richardson report’), at paras.2.1, 2.3 and 2.5.

clinical objective'.¹⁰⁵ A new MHA, 'must primarily be seen as a health measure'¹⁰⁶ which protects the patient's rights.¹⁰⁷

This preference for a patient-focused statutory framework echoed the views of a number of commentators. Campbell and Heginbotham argued that the risk formula in sections 2(2)(b) and 3(2)(c) conflated paternalism, which they saw as a legitimate basis for intervention where a patient lacks capacity, and protectionism, which was not.¹⁰⁸ They argued that the current MHA renders people with mental disorder vulnerable to detention because the compulsory powers treated the interests of other members of the community as being at least on a par with the patient's.¹⁰⁹ Consequently, people with mental disorder are subject to 'a range of unnecessary deprivations which result from crude and erroneous assumptions about mental illnesses'.¹¹⁰ They recommended that the civil commitment powers operate according to the patient's capacity; whether an individual is dangerous or not is properly a matter for the criminal law.¹¹¹

Campbell later developed this argument by contending that social control was 'conceptually and practically distinct' from medical treatment.¹¹² How 'risky' a person may

¹⁰⁵ Richardson report, *supra* n.104, at para.3.28-29.

¹⁰⁶ Richardson report, *supra* n.104, at para.2.3.

¹⁰⁷ Richardson report, *supra* n.104, at para.3.7.

¹⁰⁸ T. Campbell and C. Heginbotham, *Mental Illness: Prejudice, Discrimination and the Law*, Aldershot: Dartmouth Publishing Company Limited, 1991, at pp98, 125-127.

¹⁰⁹ *Ibid*, at p113.

¹¹⁰ *Ibid*, at p7.

¹¹¹ *Ibid*, at pp238-9.

¹¹² T.D. Campbell, 'Mental Health Law: Institutionalised Discrimination' (1994) 28 *Australian and New Zealand Journal of Psychiatry* 554, at p555.

be could have everything or nothing to do with his mental health.¹¹³ Therefore, risk should be removed from legal definitions of mental illness; if compulsory interventions to pre-empt harm are justifiable then they should apply equally to all persons regardless of their health status.¹¹⁴ While arguments in favour of a general policy of preventive detention, or 'social defence',¹¹⁵ may seem unpalatable, Campbell's point was that the 1983 Act essentially permitted this for people with mental disorder. He argued that this discrimination should be removed from mental health legislation. Rosenman went even further, arguing that mental health law is an historical anachronism that 'should not exist in a modern liberal state'.¹¹⁶ As Szmukler and Holloway later insisted, 'such measures should find no place in a mental health act'.¹¹⁷

The Richardson Committee endorsed the view that health considerations should drive reform. Its report conceived a radically new statutory framework that would view the patient through the prism of capacity. Patients deemed to require a mental health assessment, but who neither cooperated nor possessed the capacity to consent, might be subject to one on a compulsory basis.¹¹⁸ Risk would therefore continue to play a residual role. However, Richardson insisted that future mental health law would 'need to define [its]

¹¹³ Campbell and Heginbotham, *supra*, n.108, at p98. See also G. Szmukler and F. Holloway, 'Mental Health Legislation is now a Harmful Anachronism' (1998) 22 *Psychiatric Bulletin* 662, at p664.

¹¹⁴ Campbell, *supra*, n.112, at p557.

¹¹⁵ See, e.g., M. Ancel, *Social Defence: a Modern Approach to Criminal Problems*, London: Routledge & Kegan Paul, 1965.

¹¹⁶ S. Rosenman, 'Mental Health Law: An Idea Whose Time has Passed' (1994) 28 *Australian and New Zealand Journal of Psychiatry* 560, at p565.

¹¹⁷ G. Szmukler and F. Holloway, 'Reform of the Mental Health Act: Health or Safety?' (2000) 177 *British Journal of Psychiatry* 196, at p198. Emphasis original.

¹¹⁸ Richardson report, *supra* n.104, at para.5.6.

key concepts’;¹¹⁹ a point which presumably extended also to ‘risk’. The report said that it would ‘be essential to indicate the nature of risk assessment required’, possibly by introducing a ‘standard risk assessment format’.¹²⁰ This, coupled with a new focus on capacity, meant that Richardson aimed to make fundamental changes to existing mental health law.

The government’s response was lukewarm. A consultation paper published in 1999 largely welcomed the expert committee’s non-discriminatory approach, but expressed particular concern about the ‘small minority’ of people with serious mental disorders who are ‘unwilling or unable to seek the care and treatment they need voluntarily’.¹²¹ Policy-makers were apparently convinced that the compulsory powers should be contingent on the safety of the patient and the public¹²² and the assessment of risk.¹²³

By 2000, this attitude had hardened into government policy. A White Paper proposed new legislation to allow those patients posing ‘a significant risk of serious harm to others’ to be detained ‘in a therapeutic environment where they can be offered care and treatment to manage their behaviour’.¹²⁴ The contrasting language between the Richardson report and the government’s policy shows the extent of their divergence; whereas the former spoke of

¹¹⁹ Richardson report, *supra* n.104, para.5.103.

¹²⁰ *Ibid.*

¹²¹ Department of Health, *Reform of the Mental Health Act 1983: Proposals for Consultation*, The Stationery Office, CM 4480, 1999, at chapter 2, para.3.

¹²² *Ibid*, chapter 3, para.4.

¹²³ *Ibid*, chapter 5, para.6.

¹²⁴ HM Government, *Reforming the Mental Health Act – Part I: The New Legal Framework*, Cm 5016-I, December 2000, at para.1.15.

legislation guaranteeing ‘a system of patients’ rights’,¹²⁵ the latter envisaged a statutory framework in which considerations of risk would ‘always take precedence’.¹²⁶ The government contended that mental health legislation has two objectives: (i) to ensure that those who are seriously ill receive appropriate health care, and (ii) to protect the public from the behaviour of mentally disordered people who may pose a risk to their safety.¹²⁷ In its view, the 1983 Act had ‘failed to properly protect the public, patients or staff’¹²⁸ and was therefore not fulfilling one of its principal objectives. For that reason, the government sought to shore up mental health law’s protective function. It proposed a broader definition of ‘mental disorder’,¹²⁹ justified on the basis that narrow criteria are more likely to preclude compulsory care and treatment.¹³⁰ It also sought to enhance the emphasis on risk in the civil commitment framework by making admission contingent on two conditions:

- (i) the patient must be suffering from a mental disorder that is sufficiently serious to warrant further assessment or urgent treatment by specialist mental health services, and

¹²⁵ Richardson report, *supra* n.104, at para.3.7.

¹²⁶ White Paper I, *supra* n.124, at para.2.16.

¹²⁷ *Ibid*, at para.1.13.

¹²⁸ *Ibid*, at para.2.6.

¹²⁹ *Ibid*, at paras.3.3, 3.4. The government proposed that ‘mental disorder’ should be defined as ‘any disability or disorder of mind or brain, whether permanent or temporary, which results in an impairment or disturbance of mental functioning’.

¹³⁰ *Ibid*, at para.3.5.

(ii) without such intervention, the patient is likely to be at risk of serious harm, including deterioration in health, or to pose a significant risk of serious harm to other people.¹³¹

In a second White Paper, the government explicitly sought to tackle what it identified as the ‘problem’ of so-called ‘dangerous and severely personality disordered’ patients (DSPD),¹³² ‘a small...number of individuals with mental disorder...who are characterised primarily by the risk that they present to others’.¹³³ The original MHA required that mental disorders were ‘treatable’ before a patient could be admitted to hospital for treatment.¹³⁴ Because DSPDs did not fall easily within the MHA’s categories of mental disorder,¹³⁵ patients suffering from them were sometimes beyond the reach of mental health services. Therefore, the government proposed that the new MHA be drafted in such a way as to apply to patients with personality disorder. To achieve this, the ‘narrow concept’ of treatability and the categories of mental disorder would be repealed.¹³⁶ The government

¹³¹ *Ibid*, at para.3.15.

¹³² HM Government, *Reforming the Mental Health Act – Part II: High Risk Patients*, Cm 5016-II, December 2000, at para.1.8.

¹³³ *Ibid*, at para.1.3.

¹³⁴ 1983 Act, s.3(2)(b).

¹³⁵ Section 1(2) of the original 1983 Act featured four ‘categories’ of mental illness, namely: ‘mental disorder’, ‘severe mental impairment’, ‘mental impairment’, and ‘psychopathic disorder’. The nature and extent of a patient’s compulsory interaction with mental health services depended on the category in which he was placed, i.e., s.3(2)(b) of the original 1983 Act only permitted decision-makers to detain for treatment those patients with ‘psychopathic disorder’ or ‘mental impairment’ if such treatment was likely to alleviate, or prevent a deterioration of, his condition.

¹³⁶ *Ibid*, at para.3.2.

wanted a legislative framework which permitted the detention of ‘dangerous’ patients ‘for as long as they pose a risk to others as a result of their mental disorder’.¹³⁷

The contrast between Richardson’s recommendations and the government’s policy is stark. Indeed, the government even appeared to contradict its own position by proposing reforms that were inconsistent with the Department of Health’s stated aim of ‘[ensuring] health and social services, [promoting] mental health and [reducing] the discrimination and social exclusion associated with mental health problems’.¹³⁸ As Szmukler pointed out, the emphasis on risk was at odds with these more progressive goals.¹³⁹ Instead, the government sought to remove the obstacles to compulsion in the MHA by, *inter alia*, emphasising decision-makers’ roles as assessors of risk and abolishing procedural protections like the ‘treatability’ test.

The Mental Health Bills in 2002¹⁴⁰ and 2004¹⁴¹ revealed the extent of the government’s preoccupation with public safety. While they ultimately failed to reach the statute book, both Bills sought to cement risk as a ‘relevant condition’ for detention. Had it become law, the 2002 Bill would have introduced four conditions for compulsion.¹⁴² First, the patient would have to be suffering from mental disorder.¹⁴³ Secondly, that disorder would have to

¹³⁷ *Ibid*, at para.2.12.

¹³⁸ Department of Health, *National Service Framework for Mental Health: Modern Standards and Service Models*, 30th September 1999, at p14.

¹³⁹ G. Szmukler, ‘A New Mental Health (and Public Protection) Act’ (2001) 322 *British Medical Journal* 2, at p3.

¹⁴⁰ Department of Health, *Draft Mental Health Bill 2002*, Cm 5538-I.

¹⁴¹ Department of Health, *Draft Mental Health Bill 2004*, Cm 6305-I.

¹⁴² Draft Mental Health Bill 2002, clause 6.

¹⁴³ 2002 Bill, clause 6(1).

be of such a nature or degree as to warrant the provision of medical treatment.¹⁴⁴ Thirdly, if the patient were at a 'substantial risk' of causing 'serious harm to other persons' it would have to be necessary for their protection that medical treatment were provided in his case.¹⁴⁵ In any other case, it would have to be necessary for the patient's health or safety or for the protection of others that medical treatment is provided.¹⁴⁶ Finally, appropriate medical treatment would have to be available.¹⁴⁷ The 2004 Bill adopted a substantially similar approach.¹⁴⁸

In 2006, the government launched its third attempt to reform mental health law in four years. This time, the Bill sought merely to amend the 1983 Act. Contemporary records of Parliamentary Public Bill Committee proceedings in the House of Commons reveal the government's motivation for, and defence of, its reforms. Rosie Winterton MP, then the Minister of State at the Department of Health, explained that the government wanted introduce a simpler definition of 'mental disorder' because the four categories extant under the MHA were a 'legal distraction' responsible for 'arbitrary and unnecessary distinctions between patients'.¹⁴⁹ The government believed that compulsion should be determined 'by a patient's needs and *the degree of risk posed by their disorder*, not by the particular legal

¹⁴⁴ 2002 Bill, clause 6(2).

¹⁴⁵ 2002 Bill, clause 6(3)(a).

¹⁴⁶ 2002 Bill, clause 6(3)(b)(i) and (ii).

¹⁴⁷ 2002 Bill, clause 6(4).

¹⁴⁸ Draft Mental Health Bill 2004, clause 9.

¹⁴⁹ HC Public Bill Committee, *Mental Health Bill*, 24 April 2007, Session 2006-2007, 1st Sitting, Column 15.

label applied'.¹⁵⁰ The simpler definition of 'mental disorder' was clearly drafted to remove procedural obstacles. Yet, interestingly, Ms Winterton said that the change would not 'broaden the definition [of mental disorder or] bring more people into it',¹⁵¹ suggesting that the government regarded the abolition of the categories as mere simplification as opposed to fundamental reform. The proposal to abolish the 'treatability' test led to clashes with the Opposition. Tim Loughton MP, speaking in opposition to the proposed 'appropriate treatment' test, said that removing the treatability requirement 'is to permit indefinite preventive detention and to change the law from a health measure to one of social control'.¹⁵² The Opposition felt that by abolishing the 'treatability' requirement, the government would broaden the admission criteria.¹⁵³ By contrast, Ms Winterton emphasised that the treatability test had 'effectively excluded a number of people benefiting from the treatment they need'.¹⁵⁴ Here, we can see the old tension between legalism and medicalism manifest itself: while the Opposition saw compulsion as coercion, the government saw it as medical treatment.

The most interesting exchanges took place in relation to clause four of the Bill, which had been inserted by the Opposition in the House of Lords. The clause contained an 'impaired decision making' test and sought to amend sections 2 and 3 so as to make a patient's admission to hospital contingent on his capacity. If, because of his mental disorder,

¹⁵⁰ *Ibid.* Emphasis added.

¹⁵¹ HC Public Bill Committee, *Mental Health Bill*, 24 April 2007, Session 2006-2007, 1st Sitting, Column 18.

¹⁵² HC Public Bill Committee, *Mental Health Bill*, 1st May 2007, Session 2006-2007, 5th Sitting, Column 142.

¹⁵³ *Ibid.*

¹⁵⁴ *Ibid.*, at Column 154.

the patient's ability to make decisions about the provision of medical treatment were 'significantly impaired' then his admission to hospital would be legitimate, subject to the other requirements in sections 2 and 3.¹⁵⁵ This 'impaired decision-making' test mirrored the approach recommended by the Richardson Committee in 1999. While the amendment was eventually voted down in the House of Commons,¹⁵⁶ Hansard reveals the reasons behind the government's preference for a risk-based framework. Ms Winterton opposed the impaired decision-making test because it 'fundamentally changes the nature of the [proposed] legislation', whose primary focus should be 'patients' needs and the risks posed by their mental disorders'.¹⁵⁷ The minister pointed out that under the present arrangement, if a patient retains capacity but a psychiatrist believes he poses a risk then compulsion is justified. Clause four, however, would take that 'trump' away.¹⁵⁸ While the Opposition sought to inject the Richardson-style legalism into the 2006 Bill, the government amplified the importance of clinical discretion. In its view, framing the law in terms of risk would ensure that nothing stood in the way of mentally disordered people receiving treatment.¹⁵⁹ After a protracted campaign for mental health law reform lasting the best part of a decade, the Bill attained Royal Assent in 2007, signalling victory for the proponents of the risk agenda.

¹⁵⁵ 2006 Bill, clauses 4(2) and (3).

¹⁵⁶ See HC Public Bill Committee, *Mental Health Bill*, 26 April 2007, Session 2006-2007, 1st Sitting, Column 120.

¹⁵⁷ HC Public Bill Committee, *Mental Health Bill*, 26 April 2007, Session 2006-2007, 3rd Sitting, Column 80.

¹⁵⁸ *Ibid*, at Column 81.

¹⁵⁹ *Ibid*, at Column 90.

It is difficult to know whether the government saw its proposals as radically different from the Richardson Committee's ideas. Spokespersons outlining the government's position in Parliament were adamant that the Bill struck the right balance between patients' rights and public safety. In their first White Paper, policy-makers called for a statute 'that will enhance patient rights, assist in the delivery of high quality services, and provide the necessary support for the small number of people with mental health problems who may pose a risk of serious harm to others'.¹⁶⁰ In other words, the government viewed risk as an essential component in a broader framework which, ultimately, works for the benefit of the patient. While risk was the *principal* driver, the White Paper insisted that the compulsory powers should 'otherwise reflect the best interests of the patient'.¹⁶¹ Viewed in this way, perhaps it is misleading to interpret the respective positions of the Richardson Committee and the government as mutually exclusive. There was a degree of overlap. As we have seen, for all its talk of capacity, the Richardson Committee's proposed admission criteria still required decision-makers to evaluate patients' risks.¹⁶² For that reason, it is simplistic to argue that this 'battle of ideas' was a straightforward run-off between polarised policy positions. In fact, the reality was much more nuanced: the battle was over which agenda would be the *principal* driver of reform. It is clear from the policies which prevailed that the 2007 Act meant victory for the government.

What changed the debate? There is no doubt that the prominence of the risk agenda put pressure on policy-makers by injecting greater urgency into calls for reform. As Daw

¹⁶⁰ White Paper, *supra*, n.124, at para.8.1.

¹⁶¹ *Ibid*, at para.2.16.

¹⁶² Richardson report, *supra*, n.104.

points out, the government followed 'a populist agenda fuelled by...public concern and [a] media frenzy...[demanding] better public protection against those who were mentally ill and dangerous'.¹⁶³ For that reason, Richardson's approach was overlooked in favour of a more muscular risk-centric framework. Corbett and Westwood contend that the government's specific policy on DSPD patients – later dropped – reflected the 'ascendancy of the risk discourse within psychiatry...[and] the political attractiveness...of risk perceptions to appease concerns over public safety'.¹⁶⁴ There is no reason why this astute analysis should not apply to the 2007 Act's reforms more broadly.

Unsworth argues that policy-makers resort to legalism 'at times of pessimism or uncertainty about how society should respond to the problems posed by mental disorder'.¹⁶⁵ We can infer from this that medicalism, by contrast, is an expression of optimism and certainty; a society confident in its attitude towards mental illness is unlikely to interfere in medical discretion. On this view, the social and political trends leading to the 1959 Act were progressive and enlightened, in stark contrast to the cynicism which informed the legalism of the 1983 Act. In fact, it is arguable that the opposite is the case. The 2007 Act revives medicalism by expanding practitioners' discretions and dismantling legalistic obstacles. Yet it is difficult to conclude that the decade-long process which culminated in the amendments bore the hallmark of a self-assured society comfortable in its attitude towards mental illness. Policy-makers were especially concerned with the 'problem' of the management and control of risky patients but offered few solutions beyond

¹⁶³ R. Daw, 'The Mental Health Act 2007: The Defeat of an Ideal' (2007) November *Journal of Mental Health Law* 131, at p132.

¹⁶⁴ K. Corbett and T. Westwood, 'Dangerous and Severe Personality Disorder: A Psychiatric Manifestation of the Risk Society' (2005) 15(2) *Critical Public Health* 121, at p127.

¹⁶⁵ Unsworth, *supra* n.32, at p351.

detention as an end in itself. More broadly, the fundamental division between Richardson's legalism and the government's risk agenda reveals just how polarised public debate about mental illness was. Two attempts at comprehensive reform of mental health law failed within the space of five years. There was a medicalist revival, but scant evidence of optimism or certainty about how society should respond to mental illness.

We have seen that successive mental health statutes have refined the character of legalism, transforming it from a way of maintaining social order to a means of protecting patients' rights. A similar process of refinement could be said also to apply to medicalism. While both the 1959 and 2007 Acts clearly follow a medicalist agenda by lending primacy to decision-makers' discretion at the expense of legal prescription, there is an important distinction between them. The 1959 Act's medicalism reflected the revolutions in the care and treatment of people with mental disorder that took place in the post-war period. Here, the law trusted mental health practitioners to take decisions for and on behalf of their patients according to clinical need. By contrast, the 2007 Act's 'New Medicalism' expands practitioners' discretion in order to enhance the mental health service's responsiveness to risk. This subtle shift in focus introduces a covert political dimension to mental health decision-making. Of course, it would be false to contend that the 2007 Act co-opts mental health practitioners into a grand political conspiracy to detain people under the compulsory powers regardless of clinical need. As well as being morally dubious, such an arrangement would surely contravene Article 5 of the European Convention on Human Rights. What New Medicalism does, however, is reinforce risk as the key trigger for compulsion under the MHA. As an incidental effect, patients with mental disorders receive care and treatment according their clinical and social needs. By contrast, the 1959 Act's medicalism encouraged

decision-makers to improve health outcomes. In other words, the 2007 Act's brand of medicalism follows an inverted set of priorities to those pursued in the 1959 Act. In this way, the 2007 Act represents a distinct philosophical basis and a departure from the 'conventional' medicalism of its predecessors.

5. Much Ado about Nothing?¹⁶⁶ The Mental Health Act 2007

As an amending statute, the 2007 Act leaves much of the original MHA in force. It is not surprising that some people were underwhelmed. There was also a lot of anger. The Mental Health Alliance, a coalition of over seventy mental health organisations, condemned the government's 'profoundly paternalistic and authoritarian' mental health policy, which had resulted merely in a 'mild improvement' on the MHA at best.¹⁶⁷ The Alliance particularly regretted the government's failure to insert the 'impaired decision-making' test into the admission criteria, describing this as a 'missed opportunity'.¹⁶⁸

For its critics, then, the 2007 Act's amendments either went too far towards a system of preventive detention or did not go far enough in accomplishing fundamental reform. Yet, even small changes can have a big impact on the way the law operates. For example, section 1(2) of the 2007 Act, which replaces the MHA's legalistic categories of mental illness with a

¹⁶⁶ N. Glover-Thomas, *An Investigation into Initial Institutional and Individual Responses to the Mental Health Act 2007: Its Impact on Perceived Patient Risk Profiles and Responding Decision-making*, University of Liverpool and Mersey Care NHS Trust, 2011 (hereafter, 'Mersey Care study'), at p66. This quote came from a participant who had been asked to describe his/her initial impression of the 2007 Act.

¹⁶⁷ Mental Health Alliance, *The Mental Health Act 2007: Final Report*, July 2007, at p9. Available at http://www.mentalhealthalliance.org.uk/mentalhealthbill/Alliance_MHAct07_Final_Report.pdf. Accessed 8th March 2012.

¹⁶⁸ Mental Health Alliance, *supra* n.167., at pp7, 9.

simpler definition of ‘any disorder or disability of the mind’,¹⁶⁹ broadens the gateway to the compulsory powers. The 2007 Act also abolished the exclusion of ‘promiscuity’, ‘immoral conduct’ and ‘sexual deviancy’,¹⁷⁰ bringing such ‘symptoms’ within the definition of ‘mental disorder’. Whereas previously a decision-maker had to diagnose the patient according to one of four legal categories, now the mere presence of disorder or disability of the mind is enough to bring a patient within the scope of the MHA. Far from being merely cosmetic, the 2007 Act’s simpler definition was specifically designed to make the admission criteria more inclusive.

The same can be said of the ‘appropriate treatment’ test.¹⁷¹ Following the 2007 Act, an application for admission for treatment may be made in respect of a patient on the grounds that *appropriate* treatment is available for him.¹⁷² According to section 145(4),¹⁷³ ‘medical treatment’ is that which is for the purpose of alleviating, or preventing a worsening of, the patient’s mental disorder or one or more of its symptoms or manifestations. It includes nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care.¹⁷⁴ Under the original MHA, medical treatment had to be *likely* to alleviate or prevent a deterioration of the patient’s condition if he was categorised as suffering from

¹⁶⁹ 1983 Act, s.1(2) (as amended).

¹⁷⁰ 2007 Act, s.3 amended s.1(3) of the 1983 Act, which now only excludes dependence on alcohol or drugs from the definition of mental disorder.

¹⁷¹ 2007 Act, s.4 deleted the ‘treatability’ test under s.3(2)(b) of the 1983 Act and inserted a new provision, s.3(2)(d).

¹⁷² 1983 Act, s.3(2)(d).

¹⁷³ Inserted by s.7(3) of the 2007 Act.

¹⁷⁴ 1983 Act, s.145(1) as amended by s.7(2) of the 2007 Act.

psychopathic disorder or mental impairment.¹⁷⁵ By contrast, the ‘appropriate treatment’ test legitimises a patient’s detention where the treatment available is only for the *purpose* of alleviating his condition or preventing a deterioration of it. The Code of Practice makes it clear that ‘appropriate treatment’ is a lower standard than ‘treatability’: ‘medical treatment may be for the purpose of alleviating...a mental disorder even though it cannot be shown in advance that any particular effect is likely to be achieved’.¹⁷⁶ The Code does not require that the treatment is the *most* appropriate in the circumstances, nor does it have to address *every* aspect of the patient’s condition.¹⁷⁷ It may be that nursing and day-to-day care ‘in a safe and secure therapeutic environment with a structured regime’ is required to stabilise the patient, and the Code specifically includes such ‘palliative’ approaches within the ambit of appropriate treatment.¹⁷⁸ Provided that decision-makers rely, in good faith, on a course of treatment recommended for the purposes of alleviating, or preventing a deterioration in, the patient’s mental disorder, this will be enough to discharge the ‘appropriate treatment’ requirement.

On first reading the simpler definition of mental disorder and the appropriate treatment test, one might be forgiven for asking why the 2007 Act triggered so much anger and disappointment. Yet, they relocate the boundary between formal and informal treatment, making it less onerous for decision-makers to subject patients to compulsory admission. By making the MHA more responsive to risk in this way, the 2007 Act seeks to allay concerns

¹⁷⁵ 1983 Act, s.3(2)(b). Emphasis added.

¹⁷⁶ Department of Health, *Code of Practice: Mental Health Act 1983*, London: TSO, 2008, at para.6.4.

¹⁷⁷ Code of Practice, *supra* n.176, at para.6.12.

¹⁷⁸ Code of Practice, *supra* n.176, at para.6.16. The Code distinguishes nursing and specialist day-to-care care, which are forms of ‘appropriate treatment’, from simply detaining the patient in a hospital, which is not (see also para.6.17 of the Code).

that some patients might slip through the net. It therefore underestimates the impact of the 2007 Act to dismiss such amendments as trivial.

Supervised Community Treatment (SCT) is perhaps the 2007 Act's principal substantive innovation. According to the Code, the purpose of SCT is to allow 'suitable patients' to be treated 'in the community rather than under detention in hospital'.¹⁷⁹ The Community Treatment Order (CTO) seeks to achieve this objective by providing the patient with a framework of conditions requiring him to engage with mental health services and comply with a treatment plan. In order to be subject to a CTO, the patient must be liable to be detained in hospital for the purposes of section 3 of the MHA.¹⁸⁰ A patient's responsible clinician (RC) may make a CTO where the 'relevant criteria'¹⁸¹ are met and where an approved mental health professional (AMHP) states that he agrees with the RC's opinion and confirms that it is appropriate to make the order.¹⁸² All CTOs are subject to conditions requiring that the patient be available for medical examination and, where necessary, for assessment by a second opinion-appointed doctor to allow him to provide a Part 4A certificate authorising treatment.¹⁸³ RCs may also specify further conditions in a CTO which may be necessary for the purposes of managing risk and ensuring that the patient receives

¹⁷⁹ Code of Practice, *supra* n.176, at para.25.2

¹⁸⁰ 1983 Act, s.17A(2).

¹⁸¹ 1983 Act, s.17A(5) sets out the relevant criteria: (a) the patient is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment; (b) it is necessary for his health or safety or for the protection of others that he should receive such treatment; (c) subject to his being liable to be recalled...such treatment can be provided without his continuing to be detained in a hospital; (d) it is necessary that the responsible clinician should be able to exercise the power [of recall]; and (e) appropriate medical treatment is available for him.

¹⁸² 1983 Act, s.17A(4).

¹⁸³ 1983 Act, s.17B(3).

treatment.¹⁸⁴ The RC may vary¹⁸⁵ or suspend¹⁸⁶ these additional conditions to ensure that the CTO adapts to changes in the patient's circumstances. In any event, a CTO lasts for six months from the day it is made,¹⁸⁷ and may be renewed for a further six months,¹⁸⁸ and then annually thereafter.¹⁸⁹ During that time, the RC has the power to recall the patient to hospital under section 17E(1) if he thinks that (a) the patient requires medical treatment, and (b) there is a risk of harm if the patient is not recalled. The RC may also revoke a CTO where in-patient treatment lasting longer than seventy-two hours is indicated, if the conditions under section 3(2) of the MHA are satisfied and an AMHP agrees with that opinion.¹⁹⁰

The SCT provisions are the closest the MHA now gets to specifying factors material to a decision-maker's assessment of risk but the guidance is not exhaustive.¹⁹¹ This is also the case in the Code of Practice, which states that when assessing risk the RC must take into

¹⁸⁴ 1983 Act, s.17B(2). The RC has the power to vary the conditions (s.17B(4)) or suspend them entirely (s.17B(5)).

¹⁸⁵ 1983 Act, s.17B(4).

¹⁸⁶ 1983 Act, s.17B(5).

¹⁸⁷ 1983 Act, s.20A(1).

¹⁸⁸ 1983 Act, s.20A(3)(a).

¹⁸⁹ 1983 Act, s.20A(3)(b).

¹⁹⁰ 1983 Act, s.17F(4).

¹⁹¹ Section 17A(6) avoids fettering practitioners' discretion by maintaining an open-ended, non-prescriptive tone: '...the responsible clinician shall, *in particular, consider*, having regard to the patient's history of mental disorder and *any other relevant factors*, what risk there would be of a deterioration of the patient's condition if he were not detained in a hospital (as a result, *for example*, of his refusing or neglecting to receive the medical treatment he requires for his mental disorder).' (Emphasis added).

consideration the patient's clinical history and 'any other relevant factors'.¹⁹² These will vary but might include 'the patient's current mental state, his insight and attitude to treatment and the circumstances into which he would be discharged'.¹⁹³ In the SCT provisions, we can see that the MHA and its accompanying guidance leave risk assessment open to decision-makers' interpretation. A key assumption of the risk agenda, and New Medicalism more broadly, is that mental health professionals are in the best position to identify and assess patients' risks.

Perhaps unsurprisingly, then, the 2007 Act also reforms the roles and responsibilities of mental health professionals. By changing the qualifying criteria for certain roles, the 2007 Act has arguably reduced the importance of the boundary between medical- and social-model practitioners in order to foster a more cohesive response to risk among professionals. Under the original MHA, there was a clear demarcation between 'Responsible Medical Officers' (RMOs) and 'Approved Social Workers' (ASWs). RMOs were medically-qualified practitioners with the power to make recommendations in support of a patient's admission to hospital.¹⁹⁴ ASWs were social workers appointed by the local social services authority and subject to a duty to apply for a patient's admission where such action was deemed the most appropriate way of providing care and medical treatment.¹⁹⁵ While their roles and responsibilities remain largely unchanged, the 2007 Act alters the designations of these

¹⁹² Code of Practice, *supra* n.176, at para.25.9.

¹⁹³ Code of Practice, *supra* n.176, at para.25.11.

¹⁹⁴ 1983 Act, s.12(2).

¹⁹⁵ 1983 Act, s.13.

decision-makers: RMOs are now known as ‘Responsible Clinicians’ (RCs) or ‘Approved Clinicians’ (ACs),¹⁹⁶ and ASWs are now ‘Approved Mental Health Professionals’ (AMHPs).¹⁹⁷

These new titles reflect a fundamental change precipitated by the 2007 Act. As Glover-Thomas and Laing point out, the 2007 Act’s reforms permit a ‘wider pool’ of professionals to employ the MHA.¹⁹⁸ Whereas in the past only social workers could be ASWs,¹⁹⁹ now nurses, occupational therapists and psychologists can qualify as AMHPs,²⁰⁰ subject to local social services authority approval.²⁰¹ Similarly, to become an AC there is no longer a strict requirement that the candidate be medically qualified: psychologists, nurses, occupational therapists and social workers can now attain AC status.²⁰² Consequently, the boundary between the medical and social models has become more permeable as decision-makers with a background in one field can cross-qualify in another.

It is therefore difficult to see how the checks and balances on professional power included in the MHA’s admission criteria can remain effective. There are two reasons for this. First, by allowing nurses to qualify as AMHPs the reforms effectively collapse the distinction between the medical and social models. It is no longer the case that joint

¹⁹⁶ 2007 Act, ss.9-17.

¹⁹⁷ 2007 Act, ss.18-21.

¹⁹⁸ N. Glover-Thomas and J. Laing, ‘Mental Health Professionals’ in L. Gostin *et al* (eds), Principles of Mental Health Law and Policy, Oxford: OUP, 2010, at p276.

¹⁹⁹ According to section 145 of the 1983 Act, now amended.

²⁰⁰ Schedule 1 of the Mental Health (Approved Mental Health Professionals) (Approval) (England) Regulations 2008, SI 2008/1206. Medical practitioners are not permitted to qualify as AMHPs (1983 Act, s.114(2)).

²⁰¹ 1983 Act, section 114(1).

²⁰² Schedule 1 of the Mental Health (Approved Clinician) Directions 2008.

decision-making is predicated on agreement between professionals drawn from different backgrounds. Instead, the reforms allow the medical model to colonise the social model, and *vice versa*, rendering the benefits of joint decision-making redundant. Secondly, the reforms threaten to dilute the high level of clinical expertise required by the original MHA.²⁰³ Section 12(2A) now treats all decision-makers designated as ACs as ‘having special experience in the diagnosis or treatment of mental disorder’, notwithstanding the fact that they may originally have trained as psychologists, nurses, occupational therapists or social workers. For these reasons, we can argue that the 2007 Act erodes important checks and balances on decision-makers’ discretions.

In addition to these flagship reforms, the 2007 Act made a number of smaller amendments to the 1983 Act and the Mental Capacity Act 2005. These minor changes may actually serve to strengthen patients’ rights by reinforcing the remaining vestiges of legalism. First, the 2007 Act requires that ‘fundamental principles’ should appear in the Code of Practice to guide practitioners’ decision-making.²⁰⁴ All decisions should be informed, but not necessarily determined, by the ‘purpose’, ‘least restriction’, ‘respect’, ‘participation’, and ‘effectiveness, efficiency and equity’ principles.²⁰⁵ Secondly, the 2007 Act introduces ‘Independent Mental Health Advocates’ (IMHAs)²⁰⁶ to provide support²⁰⁷ and

²⁰³ 1983 Act, s.12(2) required that medical recommendations be given by (i) a practitioner approved by the Secretary of State as having special experience in the diagnosis and treatment of mental disorder, and (ii) a registered medical practitioner who has previous acquaintance with the patient.

²⁰⁴ 2007 Act, s.8 inserted s.118(2A) and (2B) into the 1983 Act.

²⁰⁵ Code of Practice, *supra* n. 176, at pp5-6.

²⁰⁶ 1983 Act, s.130A (inserted by s.30 of the 2007 Act).

²⁰⁷ 1983 Act, s.130B(1).

representation²⁰⁸ to qualifying patients²⁰⁹ subject to the MHA's compulsory powers. With the patient's consent, an IMHA has the right to see clinical records relating to his care and treatment in hospital;²¹⁰ even where the patient lacks capacity, the IMHA retains a limited right to inspect his records.²¹¹ This power enables IMHAs to represent their clients and act as their advocate before Mental Health Review Tribunals. Thirdly, sections 29(1A) and 29(2)(za) of the MHA²¹² allow the County Court to appoint or replace a nearest relative following an application by the patient. The patient's nearest relative plays an important role in the MHA framework: he may apply for compulsory admission on behalf of the patient,²¹³ veto the patient's admission for treatment,²¹⁴ or request that the patient be discharged.²¹⁵ Section 26 of the 2007 Act also amends the MHA to extend to civil partners the same right to act as nearest relatives as that which is applicable to spouses. Finally, the 2007 Act inserts the Deprivation of Liberty Safeguards ('DOLS') provisions into the Mental Capacity Act 2005.²¹⁶ We will consider the significance of the DOLS regime in chapter three, but it is worth noting that Parliament introduced the safeguards to lay down procedural protections for 'informal' patients who (i) lack capacity and (ii) are deprived of their liberty,

²⁰⁸ 1983 Act, s.130B(2).

²⁰⁹ 1983 Act, s.130C(2) states that a 'qualifying patient' is one who is liable to be detained under the MHA, subject to guardianship or a community patient.

²¹⁰ 1983 Act, s.130B(3) and (4)

²¹¹ *Ibid.*

²¹² Inserted by s.23 of the 2007 Act.

²¹³ 1983 Act, s.11(1).

²¹⁴ 1983 Act, s.11(4).

²¹⁵ 1983 Act, ss.23(2)(a) and 25.

²¹⁶ 2007 Act, s.50 and Schedules 7, 8 and 9.

thereby plugging the so-called 'Bournewood gap'.²¹⁷ Taken together, these mostly procedural changes are unlikely to have a significant impact on the operation of the MHA's compulsory powers. What they do show, however, is that the 2007 Act in no way heralds a wholesale reversion to medicalism; several of its amendments were clearly intended to boost the statutory protections of patients' rights.

Consequently, there is something of a contradiction at play in the 2007 Act. On one hand, the risk agenda clearly shaped its substantive reforms. Underlying these was a desire to make mental health legislation more responsive to risk. By simplifying the definition of mental disorder, replacing treatability with the appropriate treatment test, introducing SCT and amending decision-makers' professional roles, we can see how the 2007 Act extends practitioners' discretion to facilitate a patient's admission to hospital. On the other hand, the Act's procedural reforms seek to inject greater certainty into a patient's position when he interacts with mental health services. The Act's statement of principles, IMHA, nearest relative, and DOLS provisions arguably shore up patients' rights in a statute that for the most part can be characterised as having retreated from legalism. While the prevailing policy trend moved mental health law towards New Medicalism, it could be argued that the boost for patients' rights rather goes against the grain. At face value, it is difficult to reconcile the mutually exclusive risk and patients' rights agendas. Yet, there is little doubt that the risk agenda was the principal driving force behind the 2007 Act. We have seen how much policy-makers were motivated by risk in framing the 2007 Act at the expense of more principled, patient-centric alternatives. For that reason, concerns about patients' rights led to modest changes on the periphery of the MHA, whereas risk generated important

²¹⁷ See, R (on the application of L) v Bournewood Community and Mental Health NHS Trust [1998] UKHL 24.

substantive reforms which redefine the relationship between patients and decision-makers in favour of the latter.

6. Conclusions

This introductory chapter has charted the history of mental health law, described the rise of risk-based policy- and decision-making, and set out the key changes that the 2007 Act has made to the MHA. There are three important points to take from this discussion relating to (i) the continuity of risk, (ii) the rise of New Medicalism, and (iii) the reforms of the 2007 Act, which will inform the arguments that follow.

First, mental health law has *always* been concerned with controlling the risks posed by people with mental disorders. This thesis will not argue that the 2007 Act heralds a radical new direction for mental health legislation. Risk has been a ubiquitous – though often implicit – concept throughout the history of mental health law and policy and the 2007 Act continues that tradition. Secondly, risk was, however, the *principal* policy driver of the 2007 Act. Greater knowledge of the predictive value of patients' risk factors and growing public concern about dangerous mental illnesses fuelled the rise of the risk agenda. The proponents of patient-centric, capacity-based statutory frameworks therefore lost the battle of ideas spanning the late 20th and early 21st Centuries. For that reason, this thesis assumes that mental health law in the post-2007 Act era is shaped by a new philosophy which it calls New Medicalism. This new underpinning prefers to extend decision-makers' discretion in order to ensure that mental health professionals are highly sensitive to patients' risks. While as an incidental effect patients receive care and treatment for their mental disorders, the primary objective of the MHA is now to regulate risk. New Medicalism

places trust in decision-makers to assess patients' risks and consequently dismantles the legalistic obstacles which may inhibit that process. Finally, the reforms of the 2007 Act reveal the influence of this new philosophy. The Act broadens the definition of mental disorder, lowers the threshold for admission for treatment, weakens the checks on clinical power, and infuses the Act with the language of risk. These amendments make it less onerous for decision-makers to engage the compulsory powers and enhance their responsiveness to risk.

Chapter 2

Risk Perspectives: Finding a Context for the 2007 Act

1. Introductory

In chapter one, we saw that risk has become a prominent feature of mental health policy, giving rise to the era of New Medicalism which has culminated in the Mental Health Act 2007 ('2007 Act'). In this chapter, we discuss risk as a sociological construct. The study of the sociology of mental health law is a relatively recent development.¹ The aim of this chapter is to locate the 2007 Act within a broader social-theoretical context to establish a template which will inform the analysis in the chapters that follow.

First, applying the theories of Ulrich Beck and Anthony Giddens, this chapter examines whether the 2007 Act was driven by modern society's wider pre-occupation with risk. It distinguishes two kinds of risk: (i) the risk of a person developing a mental disorder, and (ii) the risk of a person who already has a mental disorder harming himself or other people. According to Beck and Giddens, a society preoccupied by risk becomes concerned with anticipating and avoiding the potentially catastrophic hazards which are a by-product of technological, scientific and cultural advances.² The discussion in this chapter asks whether the 'Risk Society' model maps the emergence of risk-based mental health policies, thereby

¹ V.A. Hiday, 'Sociology of Mental Health Law' (1983) 67 *Sociology and Social Research* 111.

² See, A. Giddens, *The Consequences of Modernity*, Cambridge: Polity Press, 1990; U. Beck, *Risk Society: Towards a New Modernity*, London: Sage, 1992.

applying social theory to a specific legal context.³ It will show that where the first kind of risk is concerned, modern mental health policy comports with the theories put forward by Beck and Giddens. In this way, Risk Society offers a compelling model with which to analyse the trends in English mental health policy and, to some extent, the 2007 Act. Yet, the model is imperfect: we will see that insofar as the second, narrower kind of risk is concerned, Risk Society can apply only so far.

In order to bridge this gap, we will evaluate the extent to which ‘governmentality’ – a Foucauldian constructivist interpretation of the concept of risk – might apply to mental health law and policy.⁴ While Beck and Giddens argue that risks are contemporary, man-made and high-impact analogues of natural or traditional hazards, proponents of governmentality believe that policy and decision-makers deploy risk as a tool of social control. To what extent do the reforms of the 2007 Act fit the governmentality paradigm? This chapter will argue that it may explain the rationale behind policy-makers’ desire to extend the reach of the MHA’s compulsory powers.

This chapter is intended as a theoretical complement to the legal discussion in this thesis. Its conclusions should provide a foundation on which to develop the analysis that

³ The idea of analysing mental health policy through the prism of social theory is not new. In their analysis of the Dangerous and Severe Personality Disorder (DSPD) provisions proposed by the Government in 2000, Corbett and Westwood used Risk Society to argue that policy-makers’ pre-occupation with psychiatric risk appraisal was ‘a manifestation of the late modern culture of risk’. See K. Corbett and T. Westwood, ‘Dangerous and Severe Personality Disorder: a Psychiatric Manifestation of the Risk Society’ (2005) 15(2) *Critical Public Health* 121. This chapter adopts a broader view, arguing that in fact Risk Society was instrumental in shaping the policy that drove the 2007 Act.

⁴ For a general discussion of the various sociological models of risk, see G. Mythen, ‘Sociology and the Art of Risk’ (2008) 2(1) *Sociology Compass* 299.

follows. In the first section, we consider the theory of Risk Society and how it applies to mental health law and policy.

2. Risk Society: Context for the 2007 Act?

2.1. The Theories of Ulrich Beck and Anthony Giddens

The concept of risk is not new;⁵ humanity has always been preoccupied by uncertainty about the future,⁶ and hopeless at managing it.⁷ Pre-modern societies relied on religious or magical rituals to ‘translate the experience of risk into feelings of relative security’.⁸ The core texts of Christianity and Islam, for example, teach that hazards like flooding⁹ and disease¹⁰ are subject to the will of God. Prayer and devotion were therefore the pre-modern equivalents of the contemporary assessment and management of risk.

As human knowledge and understanding of the world has improved, our interpretations of situations of risk have become more sophisticated. There are two reasons for this. First, modern society has witnessed the end of both nature and tradition as more of the physical

⁵ U. Beck, *Risk Society: Towards a New Modernity*, London: SAGE, 1992, at p48.

⁶ N. Luhmann, *Risk: a Sociological Theory*, London: Aldine Transaction 2007, at p8.

⁷ See, e.g., N. N. Taleb, *The Black Swan: The Impact of the Highly Improbable*, London: Penguin Books Limited, 2007.

⁸ A. Giddens, *The Consequences of Modernity*, Cambridge: Polity Press, 1990, at p130. See also, Luhmann, *supra* n.6, who contends, at pp8-11, that ‘divinatory practices’ were the pre-modern counterpart of modern risk calculations.

⁹ King James Bible, Genesis 6:17: *And, behold, I, even I, do bring a flood of waters upon the earth, to destroy all flesh, wherein is the breath of life, from under heaven; and everything that is in the earth shall die.*

¹⁰ Holy Qur’an 26:80: *And when I am sick, then He restores me to health.*

world has become subject to human intervention and less of our existence is lived as fate.¹¹ We have come to recognise that many adverse outcomes are contingent on human action and therefore avoidable.¹² The use of divinatory practices has therefore declined in favour of rational human action. Secondly, modern risks have contemporary causes, which are a 'wholesale product of industrialisation' and pose a global threat. In this way they differ essentially from the hazards which plagued pre-modern societies.¹³ According to the respective works of Beck and Giddens, these transformations have altered the social order and thereby given rise to 'Risk Society'.

In order to make sense of Beck and Giddens' theories, we must first recognise that Risk Society is an unintended consequence of the endpoint of the transition from pre-modernity to modernity.¹⁴ Beck asserts that one may define 'risk' as 'a systematic way of dealing with the hazards and insecurities induced and introduced by modernisation itself'.¹⁵ It follows that a Risk Society is, by definition, only possible where a state has undergone a process of industrialisation and development.¹⁶ The result is a society that functions on a 'high

¹¹ A. Giddens, 'Risk Society: the Context of British Politics' in J. Franklin (ed.) *The Politics of Risk Society*, Malden, Massachusetts: Polity Press, 1998, at pp25-26.

¹² Luhmann, *supra* n.6, at p16.

¹³ Beck, *supra* n.5, at p21.

¹⁴ Beck argues that there are two kinds of modernity: in the first, society is defined by risk; in the second, the individual becomes the basic unit of the social order. Beck describes this process as 'individualisation'. This is not particularly relevant for present purposes, but it is worth pointing out the Beck's Risk Society is part of a broader theoretical framework about modern society. See, U. Beck and E. Beck-Gernsheim, *Individualisation*, London: Sage Publications Ltd., 2002.

¹⁵ Beck, *supra* n.5, at p21..

¹⁶ See also, P. Strydom, *Risk Environment and Society: Ongoing Debates, Current Issues, and Future Prospects*, Buckingham: Open University Press, 2002. Strydom argues, at pp89-90, that Risk Society is a corollary of the decline of state and industrial societies by virtue of four factors: (i) the formation of the state, (ii) the development of science and technology, (iii) the establishment of private property, and (iv) the emergence of communication.

technological frontier' and which generates 'a diversity of possible futures'.¹⁷ Modern hazards are therefore more complex than their pre-modern counterparts¹⁸ – 'a logical consequence of an epoch of invention'.¹⁹

Beck casts these modern risks as 'man-made hybrids', which combine political, ethical, mathematical, communicational, technological, and cultural issues.²⁰ He argues that this complexity means that risks 'increasingly tend to escape the institutions for monitoring and protection [extant] in industrial society'.²¹ In other words, risks simply become too big for pre-existing institutions to deal with them. This brings ostensibly apolitical issues into the political domain. As Giddens explains, political decision-making in a Risk Society is about managing risks 'which do not [necessarily] originate in the political sphere, yet have to be politically managed'.²² At the same time, the very progression of human development, which resulted in the radicalised modernity of the Risk Society in the first place, continues to create new hazards;²³ a process known as 'manufactured uncertainty'.²⁴ Risk Society both politicises hazards, transforming risk from a value-neutral 'essential calculus' into a

¹⁷ Giddens, *supra* n.11, at p25.

¹⁸ Examples of these modern hazards include nuclear energy, climate change, disease, economic crises, and poverty.

¹⁹ H.G. Wells, *The Sleeper Awakes*, Penguin Classics, 2005, at p128.

²⁰ U. Beck, 'Politics of Risk Society' in J. Franklin (ed.) *The Politics of Risk Society*, Malden, Massachusetts: Polity Press, 1998, at p11.

²¹ U. Beck, 'The Reinvention of Politics: Towards a Theory of Reflexive Modernisation' in U. Beck, A. Giddens, and S. Lash, *Reflexive Modernisation*, Cambridge: Polity Press, 1994, at p3.

²² Giddens, *supra* n.11, at p29.

²³ Beck, *supra* n.21, at p3. Beck argued that Risk Society is not a post-modern construct, but rather a radicalised version of modernity. He explained that Risk Society emerges surreptitiously, leaving pre-existing institutional structures intact but rendering them unable adequately to assess and manage new hazards.

²⁴ Beck, *supra* n.20, at p12; Giddens, *supra* n.11, at p28.

politically-loaded concept,²⁵ and perpetuates itself, thereby continually justifying its existence.

Beck argues that this 'reflexivity' is one of the principal characteristics of the Risk Society.²⁶ While the idea that the structure of society can be a substantive source of social problems is not new,²⁷ Beck's notion of reflexivity suggests that risk both causes and solves hazards in a Risk Society. This is not necessarily a bad thing. While the notion of Risk Society might imply that risks are inevitably bad, Giddens argues that taking risks is essential if a society is to progress. Risk is a 'double-edged' phenomenon: on one hand, it refers to the possibility of harmful consequences; on the other, it is a source of economic energy and innovation.²⁸ It is also intimately bound up with questions of responsibility, implying that the Risk Society paradigm also entails obligations on its citizens.²⁹ A Risk Society which has become reflexive is a victim of its own success; a social order built on risk exhibits a promethean tendency to create new hazards as it responds to those that already exist.³⁰ As

²⁵ Beck, *supra* n.20, at p12.

²⁶ Beck, *supra* n.20, at p11. See also, Beck, *supra* n.21, at p8.

²⁷ See, e.g., R.K. Merton, 'The Sociology of Social Problems' in R.K. Merton and R. Nisbet (eds.) *Contemporary Social Problems* 4th ed., New York: Harcourt Brace Jovanovich, 1976, at p9.

²⁸ A. Giddens, *The Third Way: the Renewal of Social Democracy*, Cambridge: Polity Press, 1998, at p63; A. Giddens, *The Third Way and its Critics*, Cambridge: Polity Press, 2000, at p135. See also, D. Denney, *Risk and Society*, London: SAGE, 2005, who, at pp10-11, distinguishes the positive and negative aspects of risk: the former regards 'active risk-taking [as] a core element in the creation of a dynamic economy and innovative society'; the latter 'is concerned with the likelihood of mass exposure to physical or psychological harm'.

²⁹ A. Giddens, 'Risk and Responsibility' (1999) 62(1) *Modern Law Review* 1.

³⁰ An alternative analogy from Greek mythology is that of the many-headed Lernaean Hydra, which would grow two new heads in place of each one that was cut off. This self-perpetuating tendency is described by Beck, *supra* n.5, at p59, when he says that science is a 'legitimising patron of global risk' because it is involved in the origin and growth of the very risks it purports to tackle. At p80, he says that the Risk Society justifies a 'legitimate totalitarianism of hazard prevention', which 'takes the right to prevent the worst and, in an all too familiar manner, creates something even worse'. Ivan Illich employs a similar argument in his critique of the professionalisation of medicine, contending

a result, Beck believes that every member of society becomes trapped in 'defensive battles of various types' and has his private life reduced to a 'plaything of scientific results and theories, or of public controversies and conflicts'.³¹

In his critique of Beck's work, Mythen rather helpfully sets out the three 'pillars of risk' which underpin the theory of Risk Society.³² First, the perils facing the members of a Risk Society transcend spatial and temporal limits. Risks are no longer limited to an identifiable class of people but rather have the potential to affect everyone. Secondly, risks carry a greater catastrophic potential than they have done in the past. Hazards in a Risk Society are more likely to inflict a high degree of injury or damage. Thirdly, the hazards facing a Risk Society render its social insurance mechanisms unfit for purpose. As we have already seen, risks become 'global' problems that no single individual or institution is capable of preventing or compensating. Risk therefore becomes an all-consuming feature of modern society, redefining social relationships and re-scripting policy-makers' priorities so that every effort is made to avoid injury, loss or damage.

Risk Society has a different worldview from its pre-modern and industrial forebears. There are two consequences of this. First, policy-makers reorient society so as to make it 'future-proof' insofar as possible. There is political capital to be had in promising safety and security.³³ As Mythen points out, a Risk Society follows a 'future-oriented cultural

that while doctors aim to diagnose, treat and cure illness, in doing so they also cause 'iatrogenic' disease. See I. Illich, *Medical Nemesis: the Expropriation of Health*, London: Calder and Boyars, 1975.

³¹ Beck, *supra* n.21, at pp45-46.

³² G. Mythen, *Ulrich Beck: a Critical Introduction to the Risk Society*, London: Pluto Press, 2004, at pp18-23.

³³ Luhmann argues that the rhetoric of risk gives policy-makers political capital because they implicitly 'lay great store by the generally appreciated value of safety or security'. See Luhmann, *supra* n.6, at p19.

trajectory'.³⁴ Policy-makers therefore justify their decisions as a pre-emptive 'response' to what may happen later.³⁵ In other words, Risk Society adheres to an inverted notion of causality; as Beck says, a currently non-existent, fictive future becomes the 'cause' of contemporary experience and action.³⁶ This has profound consequences. Furedi argues that cautiousness is now embedded in institutional and bureaucratic responses to hazards.³⁷ In his view, this institutionalisation is cast as a 'responsible' way of minimising risk.³⁸ Risk-evasiveness is therefore a moral virtue. It may be that what Sunstein calls the 'Precautionary Principle' is now the guiding principle of decision-making in society.³⁹ This means that until policy or decision-makers are certain of safety they should exercise due caution.⁴⁰ We can see the extent to which the high value that society places on safety and security can have a bearing on policy and decision-making.

The second consequence of Risk Society is its impact on social policy, which deprioritises social justice in favour of risk. According to Kemshall, risk replaced need as the

³⁴ Mythen, *supra* n.32, at p142.

³⁵ Beck, *supra* n.5, at p34.

³⁶ Beck, *supra* n.5, at p34. See also, Luhmann, *supra* n.6, who says, at p37, that 'modern society represents the future as risk'.

³⁷ F. Furedi, *Culture of Fear: Risk-taking and the Morality of Low Expectation*, London: Continuum, 2005, at p108.

³⁸ *Ibid.* See also, M. Douglas, *How Institutions Think*, London: Routledge and Kegan Paul Ltd, 1986. Douglas argues, at p4, that decision-makers in institutional settings will only regard a decision as correct where it sustains 'institutional thinking'.

³⁹ C.R. Sunstein, *Laws of Fear: Beyond the Precautionary Principle*, Cambridge: Cambridge University Press, 2005.

⁴⁰ *Ibid.*, at p13.

core principle of social policy formation and welfare delivery in the 1980s.⁴¹ Since then, social policy's overriding objective has been to reduce or extinguish risk. For Beck, this would be indicative of society's transformation from a 'commonality of need' to a 'commonality of anxiety'.⁴² In the former, society encourages the pursuit of social wealth through the 'positive logic of acquisition'; in the latter, society insists on the elimination, denial or reinterpretation of risks, what Beck calls the 'negative logic of disposition'.⁴³ While the dream of the class society is that everyone wants and ought to have a share of the pie, the utopia of the Risk Society is that everyone should be spared from poisoning.⁴⁴ To achieve that objective, a Risk Society's social policy must facilitate the *regulation of risks* as opposed to the redistribution of wealth. According to Hood *et al*, the nature of modern risks is such that they justify continuing government interference with market or social processes to prevent adverse consequences.⁴⁵ This demands regulatory 'regimes' comprising complex 'institutional geography, rules, practice, and animating ideas' which facilitate the management of a particular risk.⁴⁶ Hood *et al* explain that the context and content of regimes vary, meaning that there is no single correct model of risk regulation.⁴⁷ Generally,

⁴¹ H. Kemshall, *Risk, Social Policy and Welfare*, Oxford: OUP, 2002, pp1,22. Kemshall argues that the neo-liberal agenda of the 1980s placed greater emphasis on what she calls the 'entrepreneurial self', which exercises informed choice and self-care to avoid risks.

⁴² Beck, *supra* n.5, at p49.

⁴³ Beck, *supra* n.5, at p26.

⁴⁴ Beck, *supra* n.5, at p49.

⁴⁵ C. Hood, *et al*, *The Government of Risk: Understanding Risk Regulation Regimes*, Oxford: OUP, 2004, at p3.

⁴⁶ *Ibid*, at p9.

⁴⁷ *Ibid*, at pp12, 23 and 28. The context of a risk regulation regime depends on 'the intrinsic characteristics of the problem it addresses, public and media attitudes about it, and the way power

regimes display similar processes,⁴⁸ i.e., they set goals, specify ways of gathering information and recommend ways of changing behaviour. They may be 'active' or 'corrective' by tackling the *causes* of a hazard, or 'passive' or 'preventive' by confronting its *effects*.⁴⁹ Regulatory regimes might adopt a 'homeostatic' approach, whereby they set goals in advance and convert them into quantified rules for decision-makers to follow. This approach works in a similar way to a thermostat, i.e., there is a level of tolerance above or below a pre-determined threshold but risks within a certain range demand action.⁵⁰ Alternatively, they may take a 'collibratory' approach, in which competing considerations are held together 'in a constant process of dynamic tension with no pre-set equilibrium'.⁵¹ This approach is analogous to the tension between the springs in a desk lamp. Inevitably, the design of a regulatory regime reflects the nature of the hazard and the objectives of policy-makers.

As a consequence of this shift towards regulatory social policy, Kemshall argues that 'attention shifts to blame [and] accountability' when a decision-maker does not correctly predict or prevent an adverse outcome.⁵² Douglas says that this means that 'every death [is]

or influence in concentrated in organised groups'. The regime's content comprises its 'regulatory objectives, the way regulatory responsibilities are organised, and the operating styles of regulators'.

⁴⁸ The Royal Society, *Risk: Analysis, Perception and Management*, London: Royal Society, 1992, at p136.

⁴⁹ *Ibid*, at p142. The Royal Society Study Group used the example of the risk management techniques that might be deployed in response to a natural disaster, e.g., a hurricane. An 'active' or 'corrective' response might entail the installation of slope drainage technology in order to reduce the chance of landslides. A 'passive' or 'preventative' response might entail the payment of financial compensation to the victims of the disaster.

⁵⁰ *Ibid*, at p167.

⁵¹ *Ibid*.

⁵² Kemshall, *supra* n.41, at p6.

chargeable to someone's account, every accident [is] caused by someone's criminal negligence, [and] every sickness [becomes] a threatened prosecution'.⁵³ She argues that adverse events immediately give rise to questions which seek to identify and punish the people responsible for them.⁵⁴ Rather like the common law doctrine of *res ipsa loquitur*,⁵⁵ the guiding principles of a Risk Society assume that the fact that an adverse incident has occurred speaks for itself: someone is at fault and lessons must therefore be learned. This presupposes that the citizens of Risk Society have arrogated control over the natural and traditional realms to such an extent that human intervention can pre-empt all hazards. The result is a 'defensive' society in which decision-makers deliberately (and perhaps excessively) err on the side of caution in order to avoid taking any risks at all.

Defensiveness poses a particular problem in medical practice.⁵⁶ It is trite law that doctors owe their patients a duty of care.⁵⁷ If a doctor breaches this duty and thereby causes injury, loss or damage to the patient, he will be liable in negligence. To avoid this, a

⁵³ M. Douglas, *Risk and Blame: Essays in Cultural Theory*, London: Routledge, 1992 at pp15-16.

⁵⁴ *Ibid.*

⁵⁵ 'The thing speaks for itself'. Applies in the law of tort where the court can infer the defendant's negligence on the basis that the claimant's injury, loss or damage would not normally happen without want of care on the defendant's part. Erle CJ set out the rule in Scott v London & St Katherine Docks Co (1865) 3 H&C 596, at 601: ...'*where the thing is shown to be under the management of the defendant or his servants and the accident is such as in the ordinary course of things does not happen if those who have the management use proper care, it affords reasonable evidence, in the absence of explanation by the defendants, that the accident arose from want of care.*'

⁵⁶ See, e.g., J.B. Fanning, 'Uneasy Lies the Neck that Wears a Stethoscope: Some Observations on Defensive Medicine' (2008) 24(2) *Professional Negligence* 93; N. Summerton, 'Positive and Negative Factors in Defensive Medicine: A Questionnaire Study of General Practitioners' (1995) 310 *British Medical Journal* 27; M.A. Jones and A.E. Morris, 'Defensive Medicine: Myths and Facts' (1989) 5 *Journal of the Medical Defence Union* 40; R.I. Simon, 'Coping Strategies for the Defensive Psychiatrist' (1984) 4 *Medicine and Law* 551.

⁵⁷ See, e.g., Barnett v Chelsea and Kensington Hospital Management Committee [1969] 1 QB 428. On the duty of care more generally, see Donoghue v Stevenson [1932] AC 562; Caparo Industries PLC v Dickman [1990] 2 AC 605.

doctor may act 'defensively' and in doing so will advise or undertake treatment 'which [he] think[s] is legally safe even though [he] may believe that it is not the best for [his] patient'.⁵⁸ This is despite the fact doctors' clinical decisions are judged by the standard of a responsible body of medical opinion.⁵⁹ It is argued that the prospect of their liability in negligence dissuades doctors from taking any risks which might increase the likelihood of an adverse outcome.⁶⁰ On one hand, this ensures that patients' treatment complies with the standard of care. On the other hand, defensive practice limits the medical profession's competences by putting more risky therapeutic strategies beyond use. Viewed in this light, defensive practice is a more extreme version of the Precautionary Principle; it emphasises the avoidance of risks to such an extent that it becomes counter-productive. Yet, it seems that once risk is embedded in social policy, this defensiveness becomes a virtue, signifying the high value policy- and decision-makers place on public safety.

At the root of Beck and Giddens' theories is the belief that modern society faces situations of risk that have 'little precedent in human history'.⁶¹ They believe that risk has had a profound impact on the social order, whose reflexivity ensures that it is in perpetual danger. Society's pre-occupation with risk has reconfigured public policy in order to

⁵⁸ Sidaway v Bethlem Royal Hospital Governors [1985] AC 871, *per* Lord Scarman at 887.

⁵⁹ Bolam v Friern Hospital Management Committee [1957] 1 WLR 582, *per* McNair J at 587. See also, Whitehouse v Jordan [1981] 1 All ER 267; Wilsher v Essex Area Health Authority [1988] AC 1074; Bolitho v City and Hackney Health Authority [1997] 4 All ER 771.

⁶⁰ It seems that inasmuch as defensive medicine is concerned, the courts have been willing to recognise a link between the prospect of a doctor's liability and his decision to act defensively. In Wilsher v Essex Area Health Authority [1987] QB 730, Mustill LJ, at 747, said that the tort of negligence caused a 'well recognised problem' which forces doctors to 'play for safety' in the course of their professional practices.

⁶¹ A. Giddens, *The Third Way and its Critics*, Cambridge: Polity Press, 2000 at p137.

facilitate greater management and regulation of hazards. To what extent is the policy behind the 2007 Act a manifestation of the Risk Society?

2.2. The Driver of Mental Health Policy? Applying Risk Society

‘Risk’ may relate to two things insofar as mental health policy is concerned. First, it can refer to the likelihood of a person *developing a mental disorder*. According to MIND, one in four people will experience a mental health problem in the UK in any given year.⁶² This tells policy-makers about the incidence proportion of mental disorders and allows them to devise policies which cater for the demand. Secondly, risk can describe the likelihood that a patient *already suffering from a mental disorder will harm himself or others*. While this thesis is principally concerned with the latter construction, it is worth discussing both in order to establish the extent to which Beck and Giddens’ theories might apply to mental health policy.

2.2.1. The Risk of Developing a Mental Illness

Pre-modern societies attributed mental disorders to moral deviance. Philosophers like Plato believed that immorality was to the soul what disease is to the body.⁶³ In *The Republic*, he posited that a person’s soul comprises three parts, (i) the rational, (ii) the irrational, and (iii) the spirited⁶⁴ and contended that if these components were to become unbalanced it would lead to injustice, cowardice, wickedness, and presumably also to what we would

⁶² MIND: For Better Mental Health, *How Common are Mental Health Problems?* Available at: http://www.mind.org.uk/help/research_and_policy/statistics_1_how_common_is_mental_distress. Accessed 17th June 2012.

⁶³ K. Seeskin, ‘Plato and the Origin of Mental Health’ (2008) 31 *International Journal of Law and Psychiatry* 487, at p487.

⁶⁴ Plato, *The Republic*, Book IV, at p439.

recognise as mental illness today.⁶⁵ To avoid this imbalance a person must '[set] his house in order, [gain] mastery over himself, and [become] on good terms...through discipline';⁶⁶ in other words he should lead a moral life. This 'traditional' view of insanity saw it as a manifestation of some internal failure. By contrast, in the modern era, psychiatrists recognise that extrinsic social and environmental factors play a role in triggering mental illness.⁶⁷ The expansion of scientific knowledge of mental health during the 19th and 20th Centuries led psychiatry to depart from its traditional assumptions. Writing in 1916, Salmon argued that factors like unemployment, overwork, congestion of population and child labour made it difficult for poorer members of society to maintain 'mental hygiene'.⁶⁸ In the post-war era, Felix and Bowers contended that an increasingly complex world with highly-concentrated and more easily-mobilised sources of power meant that 'the need for sanity is patent'.⁶⁹ Psychiatrists thus drew a link between social, political and environmental conditions on one hand, and mental illness on the other. In this way, scientific understanding of the aetiology of mental disorders became more sophisticated and complex.

⁶⁵ *Ibid*, at p444.

⁶⁶ *Ibid*, at p439.

⁶⁷ See, e.g., Rethink, *What Causes Mental Illness?* Available at: http://www.rethink.org/about_mental_illness/what_causes_mental_illness/index.html. Accessed: 17th June 2012. Rethink explains that these social and environmental factors might be things such as where a person lives, his place or work, his relationships with family and friends, and how and where he can relax.

⁶⁸ T.W. Salmon, 'Mental Hygiene' in M.J. Rosenau (ed.), *Preventive Medicine and Hygiene*, New York: D. Appleton & Co, 1916, at p331.

⁶⁹ R.H. Felix and R.V. Bowers, 'Mental Hygiene and Socio-environmental Factors' (1948) 26(2) *The Millbank Memorial Fund Quarterly* 125.

What psychiatry experienced during the 20th Century therefore was arguably the same decline of nature and tradition which Giddens identified as a consequence of modernisation more broadly. Whereas in the past doctors might have regarded mental disorder as a sign of a patient's lack of probity, now they rely on objective evidence which suggests that certain social and environmental factors predispose some people to an increased likelihood of developing a mental illness. The ability to identify these 'triggers' makes it possible – at least in theory – for policy-makers and mental health professionals to take steps to reduce the incidence proportion of mental illness. In this way, scientific research has demystified mental illness, making its aetiology contingent on human action rather than attributable to fate or immorality. There is also evidence that Beck's notion of a reflexive social order may apply to psychiatry because modernity has created new hazards to mental health. While Beck's scholarship emphasises that industrial or technological processes manufacture the new dangers of modernity, there is no reason why we should limit our enquiry only to tangible things. Flynn suggests that modern lifestyles are equally responsible for introducing new risks to society.⁷⁰ These 'modern' factors put more people 'at risk' of mental illness today than at any time in the past. For example, research has linked the trauma of life in the 21st Century,⁷¹ terrorism,⁷² democratic processes,⁷³ the Internet,⁷⁴ climate change,⁷⁵

⁷⁰ R. Flynn, 'Health and Risk' in G. Mythen and S. Walklate (eds.) *Beyond Risk Society: Critics Reflections on Risk and Human Security*, Oxford: OUP, 2006, p81.

⁷¹ See, e.g., T.W. Miller, 'Trauma, Change and Psychological Health in the 21st Century' (2007) 62(8) *American Psychologist* 887.

⁷² See, e.g., M.A. Schuster, *et al*, 'A National Survey of Stress Reactions after the September 11 2001 Terrorist Attacks' (2001) 345 *New England Journal of Medicine* 1507.

⁷³ See, e.g., T.J. Classes and R.A. Dunn, 'The Politics of Hope and Despair: the Effect of Presidential Election Outcomes on Suicide Rates' (2012) 91(3) *Social Science Quarterly* 593.

unemployment,⁷⁶ social isolation,⁷⁷ debt and poverty,⁷⁸ economic policy,⁷⁹ and industrialised labour⁸⁰ to poor mental health outcomes. All of these ‘hazards’ are a direct consequence of, or further driven by, human endeavour and economic development. As they propel society’s progress, they have also ‘manufactured’ new risks to mental health. Here we can see a compelling parallel with Beck’s theory of reflexive modernisation.

The effects of this reflexivity may have fundamentally recalibrated the priorities of modern mental health policy, giving rise to a greater emphasis on preventive strategies. It is true that there are strong moral reasons for addressing the root causes of mental disorder.

⁷⁴ See, e.g., S.R. Cotten, *et al*, ‘The Importance of Type, Amount and Timing of Internet Use for Understanding Psychological Distress’ (2011) 92(1) *Social Science Quarterly* 119; P. DiMaggio, *et al*, ‘Social Implications of the Internet’ (2001) 27(1) *Annual Review of Sociology* 307.

⁷⁵ See, e.g., A.J. McMichael, ‘Editorial: Drought, Drying and Mental Health: Lessons from Recent Experiences for Future Risk-lessening Policies’ (2011) 19 *Australian Journal of Rural Health* 227; C.R. Hart, *et al*, ‘Improving the Mental Health of Rural New South Wales Communities Facing Drought and Other Adversities’ (2011) 19 *Australian Journal of Rural Health* 231.

⁷⁶ See, e.g., P.A. Creed, *et al*, ‘The Role of Satisfaction with Occupational Status, Neuroticism, Financial Strain and Categories of Experience in Predicting Mental Health in the Unemployed’ (2001) 30 *Personality and Individual Differences* 435; A.H. Winefield, ‘Unemployment: its Psychological Costs’ in C.L. Cooper and I.T. Robertson (eds.) *International Review of Industrial and Organisational Psychology*, Chichester: Wiley, 1995.

⁷⁷ See, e.g., C.D. Sherbourne, ‘The Role of Social Support and Life Stress Events in use of Mental Health Services’ (1988) 27(12) *Social Science and Medicine* 1393.

⁷⁸ See, e.g., E. Selenko and B. Batinic, ‘Beyond Debt: a Moderator Analysis of the Relationship between Perceived Financial Strain and Mental Health’ (2011) 73 *Social Science and Medicine* 1725; D. Stuckler, *et al*, ‘The Public Health Effect of Economic Crises and Alternative Policy Response in Europe: an Empirical Analysis’ (2009) 374 *The Lancet* 315; M.L. Bruce, *et al*, ‘Poverty and Psychiatric Status: Longitudinal Evidence from the New Haven Epidemiologic Catchment Area Study’ (1991) 48 *Archives of General Psychiatry* 470.

⁷⁹ See, e.g., R. Warner, *Recovery from Schizophrenia: Psychiatry and Political Economy*, 3rd ed., London: Routledge, 2004.

⁸⁰ See, e.g., J.T.F. Lau, *et al*, ‘Suicides in a Mega-size Factory in China: Poor Mental Health among Young Migrant Workers in China’ (2012) *Occupational and Environmental Medicine* 1. Available at: <http://oem.bmj.com/content/early/2012/02/27/oemed-2011-100593.full.pdf>. Accessed: 12th June 2012. See also, J. Siegrist, ‘Adverse Health Effects of High-effort/Low-reward Conditions’ (1996) 1 *Journal of Occupational Health Psychology* 27.

By virtue of their improved knowledge of what causes mental illness, psychiatrists can actually work to *prevent* mental disorders arising in the first place. They are thus in a similar ethical position to a doctor who has access to a vaccine which will prevent a patient from contracting a deadly or debilitating disease. In both instances, a doctor's withholding treatment may violate the Hippocratic tenet, *primum non nocere*.⁸¹ Yet, the shift to preventive practices presupposes a broad input from policy- and decision-makers empowered to improve social and environmental conditions. Preventive strategies are radically different from the 'reactive' approach implied by the MHA, which legitimises intervention in a patient's case *only after* he has manifested a mental disorder of the requisite nature or degree.⁸² In 2009, the Future Vision Coalition recommended that Parliament amend the MHA so as to reduce its emphasis on public protection and incorporate preventive and recovery-oriented priorities.⁸³ A report by the Centre for Social Justice adopted a similar position, calling for policy-makers to sharpen their focus on alleviating the so-called 'pathways to poverty' which contribute to poor mental health.⁸⁴ Following a change of government in 2010, it appears that the goal of pursuing preventive strategies has crystallised into policy. In *No Health Without Mental Health*, the government

⁸¹ 'First, do no harm'. On biomedical ethics generally, see T.L. Beauchamp and J.F. Childress, *Principles of Biomedical Ethics*, 6th ed., Oxford: OUP, 2009.

⁸² 1983 Act, ss.2 and 3.

⁸³ The Future Vision Coalition, *A Future Vision for Mental Health*, 2009, at p30.

⁸⁴ Mental Health Working Group, *Completing the Revolution: Transforming Mental Health and Tackling Poverty*, London: Centre for Social Justice, 2011, at p34. These are: worklessness, benefit-dependency, and a propensity to get into debt; poor educational attainment; family breakdown and social isolation; and addiction to drugs or alcohol.

put forward its key objective of improving mental health outcomes for more people.⁸⁵ Crucially, the Coalition has said that it hopes to accomplish this by dismantling ‘top-down direction’ in favour of a bottom-up campaign to promote mental health and wellbeing.⁸⁶ It hopes that this will facilitate steps to promote positive parenting, tackle inequality, combat tobacco, alcohol and drug misuse, and encourage employment – all of which it recognises as conducive to good mental health.⁸⁷ It remains to be seen whether Parliament will incorporate these preventive strategies into the MHA. For now, it is enough to point out that the realignment of health policy in this way is consistent with the Risk Society’s reflexivity and pre-occupation with the future.

It seems, then, that the theories of Risk Society proposed by Beck and Giddens to some extent map the general trends in mental health policy and practice. Yet, they do not fit perfectly. It is true that Beck had hazards like a nuclear meltdown in mind when he developed his theories, and it is therefore difficult to argue that the risks of developing a mental disorder defy spatial or temporal limits, pose a catastrophic threat potential, or exist beyond the regulatory reach of pre-existing institutional frameworks in quite the same way.

⁸⁵ HM Government, *No Health Without Mental Health: a Cross-government Mental Health Outcomes Strategy for People of all Ages*, 2011. HM Government based its mental health strategy on six objectives. They are:

- *More people will have good mental health.*
- *More people with mental health problems will recover.*
- *More people with mental health problems will have good physical health.*
- *More people will have a positive experience of care and support.*
- *Fewer people will suffer avoidable harm.*
- *Fewer people will experience stigma and discrimination.* (See chapter 3)

⁸⁶ *Ibid*, at para.1.11.

⁸⁷ *Ibid*, at paras.1.14, 3.10, 6.6.

It would overstate the magnitude of the risk if mental illnesses were considered analogous to the low-probability, high-impact hazards posed by climate change or nuclear energy. Nevertheless, we must not dismiss the Risk Society thesis entirely. Just because mental illness does not kill or injure as many people as, say, a nuclear catastrophe does not necessarily mean that it is any less of a priority. Risk must be a relative concept; it would be absurd if one could count only the most catastrophic and indiscriminate hazards as genuine risks. In the case of health specifically, there is undoubtedly political capital to exploit in promising to reduce or eliminate the risk of poor mental health. Indeed, the fact that mental illness is more commonly experienced than nuclear accidents in society might mean that there is an even greater urgency in taking steps to reduce the risks. Sunstein points out that people rely on certain heuristics when it comes to hazards: those with which they are *familiar* and which appear more *salient* are actually more likely to be considered a priority over those with which they are less familiar or that appear less salient.⁸⁸ Hazards to public health seem intuitively more familiar and salient than some of the risks on which Beck focuses. It follows that there is no reason why the Risk Society theory cannot explain risk-based health policies.

Indeed, the distinction between the risk of mental illness and the risks of more serious hazards might not be as great as first appears. According to the latest estimates, the UK population currently stands at sixty-three million people, approximately forty-nine million of whom are over the age of eighteen.⁸⁹ If MIND's statistics are accurate,⁹⁰ a quarter of the UK

⁸⁸ Sunstein, *supra* n.39, at pp36-37.

⁸⁹ Office for National Statistics, *Statistical Bulletin: Annual Mid-year Population Estimates 2010*, June 2011. The UK population was 62,262,000 in mid-2010. Since 2001, the population has grown at an average rate of 0.6% *per annum*. Assuming this rate of growth has remained constant, in mid-2012 the UK population stands at approximately 63,011,400.

adult population – up to 12 million people – are at risk of experiencing a mental health problem in any given year. Furthermore, ten *per cent* of the adult population (approximately 4.9 million people) suffers from depression, thirteen *per cent* has a personality disorder and around 245,000 people have schizophrenia.⁹¹ Mental health problems are therefore common among British adults, suggesting that they are both familiar and salient. Indeed, mental disorders account for almost a quarter of the total burden of disease in the United Kingdom, whereas cancer and heart disease make up less than a fifth each.⁹² They also account for a large chunk of public expenditure on health services. HM Treasury plans to spend £137 billion on health in 2013-2014.⁹³ According to Harker, the National Health Service (NHS) spent eleven *per cent* of its budget in 2010-2011 in England on mental health, representing the largest category of expenditure.⁹⁴ At £11.9 billion this was more than double the expenditure on oncology (£5.8 billion) and around a third greater than spending on circulatory problems (£7.7 billion), which represented the second most expensive category. If the NHS continues this trend in 2012-2013, mental health will receive approximately £14 billion in public funds in England alone. Interestingly, the risks of developing cancer⁹⁵ or dying of heart disease⁹⁶ are much greater than suffering mental

⁹⁰ MIND, *supra* n.62.

⁹¹ *Ibid.*

⁹² Care Quality Commission, *Monitoring the Mental Health Act in 2011/12*, at p8. Available at: http://www.cqc.org.uk/sites/default/files/media/documents/cqc_mentalhealth_2011_12_main_fin_al_web.pdf. Accessed: 12 February 2013.

⁹³ HM Treasury, *Budget 2013*, March 2013, London: The Stationery Office, HC 1033.

⁹⁴ R. Harker, *NHS Funding and Expenditure*, 3rd April 2012, House of Commons Library, SN/SG/724.

⁹⁵ See, e.g., Cancer Research UK, which estimates that approximately there is a 40% chance of a person developing cancer during his/her lifetime. Available at: <http://info.cancerresearchuk.org/cancerstats/incidence/risk/#Lifetime>. Accessed: 3rd July 2012.

illness in the UK and yet spending on mental health services by far exceeds that given to their oncological and cardiovascular equivalents. While its effects may not be catastrophic or indiscriminate, mental illness in the UK affects a sizeable proportion of the population and has considerable implications on public spending. This is magnified to an even greater extent on the global scale. According to the World Health Organisation (WHO), depression affects 121 million people worldwide and 24 million suffer from schizophrenia.⁹⁷ This compares with the 34 million people estimated to be living with HIV worldwide in 2010 and 216 million cases of malaria in the same year.⁹⁸ The WHO states that mental, neurological and substance use disorders are prevalent around the world, accounting for fourteen *per cent* of the global disease burden and a third of all non-communicable diseases.⁹⁹ It describes mental illness as a 'major contributor' to morbidity and premature mortality.¹⁰⁰ Perhaps compounding this problem, nearly half of all people with mental disorders in developed countries and up to eighty-five *per cent* in less developed countries go without treatment.¹⁰¹ A lack of a universal commitment to achieving better mental health outcomes appears to be to blame for this discrepancy. In its *Mental Health Atlas*, the WHO estimates that only seventy-two *per cent* of the world's population lives in countries with a dedicated

⁹⁶ See, e.g., The British Heart Foundation, which estimates that cardiovascular disease accounts for a third of all deaths in the UK. Available at: <http://www.bhf.org.uk/heart-health/conditions/cardiovascular-disease.aspx>. Accessed: 3rd July 2012.

⁹⁷ World Health Organisation, *Mental Health*. Available at http://www.who.int/mental_health/management/en/ Accessed: 17th June 2012.

⁹⁸ World Health Organisation, *Global Health Observatory Data Repository*. Available at <http://apps.who.int/ghodata/> Accessed: 17th June 2012.

⁹⁹ World Health Organisation, *Mental Health Gap Action Programme: Scaling Up Care for Mental, Neurological and Substance Use Disorders*, Geneva: World Health Organisation, 2008, at p6.

¹⁰⁰ *Ibid.*

¹⁰¹ *Ibid*, at p7.

mental health policy, and just over half enjoy the protection of mental health legislation.¹⁰² Indeed, mental health spending *per capita* is 200 times higher in developed countries than in less-developed states, creating an enormous deficit which is reflected in the global disease burden statistics.

There is a compelling argument, then, that the Risk Society thesis provides a theoretical context for modern mental health policy. Trends in psychiatry exhibit the same decline of nature and tradition and reflexive modernisation which Giddens and Beck described. Expanding scientific knowledge of the aetiology of mental disorder has identified a link between social and environmental factors and adverse mental health outcomes. While these outcomes may never achieve catastrophic parity with nuclear accidents or climate change, mental health policy appears increasingly pre-occupied with the objective of preventing mental illnesses arising *in the future*. When one considers the global reach of the risk of mental illness, its debilitating effects or the challenge it poses for mental health professionals and healthcare institutions, it is perhaps unsurprising that taking steps to reduce or extinguish risks has become a priority for policy-makers. The Risk Society thesis therefore maps the trends that seem to be at work. To what extent can the same be said of the more specific risk that a person with mental disorder will cause harm to himself or others?

2.2.2. The Risk that a Person with Mental Disorder will Cause Harm to Himself or Others

The second construction of risk has a much narrower application than the likelihood of a person developing a mental disorder. Here, the patient already has a mental disorder, so

¹⁰² World Health Organisation, *Mental Health Atlas 2011*, Geneva: World Health Organisation, 2011, at pp17, 22.

the hazards that policy- and decision-makers seek to avoid are much more specific because they are *contingent on* – but not necessarily a corollary of – the patient’s diagnosis. It follows that the hazards which inform mental health policy in this context are those which are adverse for the patient or the public. These might include the patient’s committing suicide, self-harming, self-neglecting, or directing violence towards others.¹⁰³

It is worth pointing out that much of what was said in section 2.2.1 above is equally applicable here. The policy responses to the risk of harm to the patient or other people bear at least some of the hallmarks of the Risk Society. The so-called ‘rise of risk’ we discussed in chapter one is entirely consistent with Beck and Giddens’ theories. We saw in chapter one that better knowledge of patients’ risk factors made it easier to administer care in the community. As a result, more patients were living outside the confines of the hospital, which in turn created new risks of adverse events. Here again we witness reflexivity: new knowledge led to a ‘modern’ idea like deinstitutionalised care which ‘manufactured’ newer risks and thereby fed public anxiety. The more progress clinicians made in identifying links between mental disorder and adverse outcomes, the more concerned the public became about its safety. We have already seen that members of the public became especially anxious that they were at risk from indiscriminate and potentially catastrophic attack by mentally ill people at large in the community after the murder of Jonathan Zito in 1992. When this dynamic is applied to Mythen’s ‘pillars of risk’, it becomes clear that this narrower application of risk is much closer to Beck’s notion of the Risk Society than the broader construction discussed in section 2.2.1. For the public, the Zito case suggested that

¹⁰³ Mental health policy usually recognises three hazards in this context: violence (including antisocial and offending behaviour), self-harm/suicide, and self-neglect; see, e.g., Department of Health, *Best Practice in Managing Risk: Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services*, 2007, at p7. Available at: <http://www.nacro.org.uk/data/resources/nacro-2007070300.pdf>. Accessed: 1st October 2009.

this risk was (i) indiscriminate, (ii) catastrophic, and (iii) beyond the control of any single agency. For policy-makers, this meant that there was a greater incentive to exploit the political capital attendant on promises to pursue risk-based reform of mental health law.

It is possible to identify two particular consequences of the Risk Society's influence on the parts of mental health policy concerned with the risk of harm: (i) the emergence of regulatory strategies, and (ii) the development of a culture of responsibility and blame.

First, the emphasis on risk led to new legal powers that emphasise *regulation* rather than achieving positive health outcomes. This is consistent with Beck's view that a 'commonality of anxiety' sets the priorities of social policy. It also implicitly rejects the idea that it is possible for a patient with mental disorder to cease being a risk once his clinical team has labelled him as such. In other words, clinicians do not determine patient risk profiles according to a binary 'risk/not a risk' assessment. Instead, the patient finds himself on an 'escalator of dangerousness', up and down which he moves at different moments of his life.¹⁰⁴ Risk is therefore a 'sticky' label which adheres to the patient, rendering all his behaviour subject to interpretation through the prism of risk.¹⁰⁵ This continuum thereby justifies continuing regulation by clinical decision-makers. Pursuant to this, the 2007 Act's SCT provisions are the latest in a line of regulatory legal mechanisms which includes guardianship¹⁰⁶ and aftercare under supervision.¹⁰⁷ All of these instruments have shared a

¹⁰⁴ D. Denney, *Risk and Society*, London: SAGE, 2005, at pp115-116.

¹⁰⁵ On the social impact of labelling a person with a mental disorder, see J.A. Clausen, *supra* n.27. Clausen says, at p126, that once the patient is labelled as a deviant, he 'is expected to conform to the prescriptions for the role in which he has been cast', which means he becomes defined by his diagnosis.

¹⁰⁶ 1983 Act, ss.7-10. An application for guardianship confers on a local social services authority, or another nominated person, the power to require the patient to live in a specific place, attend medical appointments or education and training sessions, and grant access to the patient to any mental health decision-maker.

common goal: to stabilise patients within optimum limits in order to regulate their behaviour in the community. In this way, they amount to what Hood *et al* would recognise as homeostatic regulatory 'regimes'. SCT involves a 'compact' between the clinical team and the patient. If the patient complies with the terms of his CTO and treatment plan, then his clinical team will be happy to monitor his progress in the community. If he does not, then the clinical team can recall the patient to hospital and even revoke the Order to ensure that he receives treatment.¹⁰⁸ The CTO is also contingent on the patient being in a category of risk that might be described as a 'halfway house' between that which necessitates full civil commitment and that which permits informal care and treatment without the MHA. SCT therefore requires a co-operative patient to be located within an optimum range of risk commensurate with de-institutionalised supervision. This necessitates a close degree of regulatory oversight which continually evaluates the patient's risks. For that reason, it is perhaps not a coincidence that the SCT provisions are the first in the MHA to refer explicitly to risk.¹⁰⁹

Secondly, the gravity of the risk has contributed to a blame culture. We know that a Risk Society assumes that many hazards are amenable to prediction and control and that policy- and decision-makers are presumed to be innately risk-averse. Thus, any failure to take the necessary steps to avoid, or at least minimise the fallout of, a particular hazard is evidence

¹⁰⁷ This was an innovation of the Mental Health (Patients in the Community) Act 1995, which inserted ss.25A-25J into the 1983 Act. Patients on 'supervised discharge' were subject to a legal order which put them under the supervision of a health authority, which had to ensure that patients received the aftercare services provided for them under 1983 Act, s.117. It was repealed by Schedule 11, Part 5 to the 2007 Act.

¹⁰⁸ Department of Health, *Code of Practice: Mental Health Act 1983*, London: TSO, 2008, at paras.25.38-25.40.

¹⁰⁹ See, e.g., MHA 1983, ss.17A(6), 17B(2), 17E(1)(b), 20A(7).

of culpable failure. The emergence of a culture of responsibility and blame can therefore be regarded as a natural consequence of the Risk Society. This poses a particular problem in mental health practice. Alaszewski argues that the pre-occupation with risk has distorted mental health practice so that professional accountability is now primarily concerned 'with responsibility for losses... [and] preventing harm to individuals, users, agency employees and the public'.¹¹⁰ As a result, assessments of risk carry a dual purpose: (i) they are clinical fact-finding processes which enable decision-makers to calculate the likelihood of a patient's causing harm to himself or others and act accordingly, and (ii) they are defensive exercises which ensure that decisions are 'clinically, logically and medico-legally defensible'.¹¹¹ It may be that the latter purpose has permanently warped the objectives of mental health practice.

It is easy to see why. In 1994, guidelines issued by the Department of Health made it mandatory for public inquiries to investigate all adverse incidents perpetrated by people with mental disorder following their discharge into the community.¹¹² An independent investigation must now be undertaken in any case where: (i) a person commits a homicide within six months of his release from specialist mental health services, (ii) it is necessary to comply with the state's obligations under Article 2 of the European Convention on Human Rights, or (iii) the Strategic Health Authority determines that an adverse event warrants independent investigation, e.g., if a cluster of suicides gives rise to concerns about

¹¹⁰ A. Alaszewski *et al*, 'Professionals, Accountability and Risk' in A. Alaszewski, *et al* (eds.) *Risk, Health and Welfare: Policies, Strategies and Practice*, Buckingham: Open University Press, 1998, at p94.

¹¹¹ M. Vinestock, 'Risk Assessment: a Word to the Wise?' (1996) 2 *Advances in Psychiatric Treatment* 3, at p4.

¹¹² Department of Health, *Guidance on the Discharge of Mentally Disordered People and Their Continuing Care in the Community*, Circular HSG (94)(27) and LASSL (94)(4), London, 1994.

significant systemic failure.¹¹³ According to Blom-Cooper, the principal objectives of a public inquiry are to establish the facts, identify individual culpability, survey the arrangements that led to the event, and name and shame those responsible to pre-empt a crisis of public confidence.¹¹⁴ In other words, they are an occasion to identify what went wrong and blame those responsible. According to Warner, there were over sixty public inquiries in the ten years since they became compulsory, reflecting a high level of anxiety about the perceived failure of community care.¹¹⁵ In fact, Warner's may be a conservative estimate; Prins reckons that there have been over 400 inquiries since 1994.¹¹⁶ In any event, Warner argues that the inquiry reports have embedded the link between mental illness and violence in the public consciousness.¹¹⁷ It is true that many of the inquiries were convened to investigate high profile homicides which had captured the public imagination.¹¹⁸ This may explain why the public continues to believe that mental health policy should emphasise its protection

¹¹³ Department of Health, *Independent Investigation of Adverse Events in Mental Health Services*, London: TSO, 2005, at pp1-2. Available at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4113574.pdf. Accessed: 13th June 2012.

¹¹⁴ L. Blom-Cooper, 'Public Inquiries' (1993) 46(2) *Current Legal Problems* 204, at p205.

¹¹⁵ J. Warner, *Homicide Reports as Active Texts*, The Open University, at p2. Available at: <http://www.kent.ac.uk/scarr/events/finalpapers/warner.pdf>. Accessed: 13th June 2012.

¹¹⁶ H. Prins, 'Homicide and Allied Inquiries: In Whose Best Interests?' (2010) 50 *Medicine, Science and the Law* 4, at p7.

¹¹⁷ *Ibid*, at p5. See also, P. Fennell, 'Radical Risk Management, Mental Health and Criminal Justice' in N. Gray *et al* (eds.) *Criminal Justice, Mental Health and the Politics of Risk*, London: Cavendish Publishing Ltd, 2002.

¹¹⁸ See, e.g., C. Heginbotham *et al*, *The Report of the Independent Panel of Inquiry Examining the Case of Michael Buchanan*, London: North West London Mental Health Trust, 1994; J. Perry and B. Sheldon, *Richard Phillips Inquiry Report*, London: City and Westminster and Kensington, Chelsea and Westminster District Health Authority, 1995; R. Francis *et al*, *Report of the Independent Inquiry into the Care and Treatment of Michael Stone*, South East Coast Strategic Health Authority, 2006. For a summary of other high profile homicide inquiries, see H. Prins, *Will They Do It Again? Risk Assessment and Management in Criminal Justice and Psychiatry*, London: Routledge, 1999, chapter 4.

from people with mental illness.¹¹⁹ While attitudes to mental illness have generally improved, the belief that people are in danger from those with mental disorder has remained a stubborn feature of public debate. This is despite evidence that long-term signs of dangerousness are manifest in only a subsection of those patients who go on to be violent.¹²⁰ By asking ‘what went wrong?’ public inquiries reinforce negative stereotypes by implying that people with mental disorders are essentially dangerous and therefore require active measures to remain under control. This puts an onus on mental health decision-makers to assume a level of responsibility that perhaps exceeds their professional competence. More importantly, it justifies tighter supervision of the patient, fundamentally transforming his engagement with mental health services from a therapeutic experience to one focused on the management of risk.

Perhaps the most well-known public inquiry into a homicide committed by a person with mental disorder was that which investigated the care and treatment of Christopher Clunis.¹²¹ The report found that Clunis’ care and treatment was ‘a catalogue of failure and

¹¹⁹ In an NHS survey of public attitudes to mental illness in 2011, only 36% agreed that less emphasis should be placed on protecting the public from people with mental illness. Yet, attitudes to mental illness more broadly have improved over time: 77% of those surveyed agreed that ‘mental illness is an illness like any other’; 91% agreed that sufferers of mental illnesses deserve the best possible care; and 79% agreed that the best type of care for people with mental illness is given in the community. See, National Health Service, *Attitudes to Mental Illness: 2011 Survey Report*, The Health and Social Care Information Centre, 2011. Available at: http://www.ic.nhs.uk/webfiles/publications/mental%20health/mental%20health%20act/Mental_illness_report.pdf. Accessed: 17th June 2012.

¹²⁰ E. Munro and J. Rungay, ‘Role of Risk Assessment in Reducing Homicides by People with Mental Illness’ (2000) 176 *British Journal of Psychiatry* 116. Munro and Rungay looked at a sample of forty inquiry reports, finding that twenty-six homicides were preventable; of these, sixteen patients showed long-term risk indicators.

¹²¹ J. Ritchie *et al*, *The Report of the Inquiry into the Care and Treatment of Christopher Clunis*, London: HMSO, 1994.

missed opportunity' which culminated in his killing Jonathan Zito in December 1992.¹²² For example, the different agencies involved in Clunis' case failed to communicate with each other, overlooked his clinical history and neglected his aftercare arrangements.¹²³ The inquiry found that Clunis had exhibited violent tendencies on several occasions, which ought to have signalled the high level of risk he posed to others.¹²⁴ The inquiry said that decision-makers tended to miss the bigger picture, e.g., they overlooked violent incidents, focused too much on delivering short-term care, allowed geographical boundaries to interfere with treatment provision, and deferred difficult decisions.¹²⁵ Underlying the Clunis inquiry report is an assumption that if the decision-makers had acted otherwise then the adverse outcome might have been avoided. On the issue of risk specifically, the inquiry concluded that there were examples of 'poorly considered and sometimes misleading predictions' of risk in Clunis' case which had 'led to false reassurance about his potential for dangerous behaviour'.¹²⁶ While the inquiry insisted that no single individual or agency was at fault,¹²⁷ its report blamed systemic failure for allowing the factors that contributed to the death of Jonathan Zito to prevail.

It is easy to see how public inquiries contribute to a blame culture because they perpetuate the notion that the intervention of practitioners is necessary to break the chain of causation between mental illness and adverse outcomes. This is a natural consequence of

¹²² *Ibid*, at para.42.1.1.

¹²³ *Ibid*, at para.42.2.1.

¹²⁴ *Ibid*, at paras.12.2, 12.5, 24.2, 35.1, 35.2, 35.3, 35.4, 36.

¹²⁵ *Ibid*, at para. 42.2.3.

¹²⁶ *Ibid*, at para.49.0.2.

¹²⁷ *Ibid*, at para.42.1.1.

a Risk Society in which great emphasis is placed on the human capacity to predict and prevent hazards. While it may be true that decision-makers can often take steps to prevent adverse outcomes, Szmuckler explains that the assumption that clinical decision-making is always the difference between good and bad outcomes is deeply misconceived; not all risk factors for violence in people with mental illness inevitably lead to homicide.¹²⁸ Yet, the rationale behind *post-hoc* inquiries does not appear to recognise such shortcomings. Instead, inquiries implicitly accuse clinicians of failure, placing them in an 'invidious position' in which the consequences of both their retrospective (would you have acted differently?) and prospective (what would you do now?) viewpoints are considered.¹²⁹ Once an inquiry is convened, the implication is that someone is to blame and it therefore can manipulate its investigation until it finds fault. This completely overlooks the fact that no decision-maker can eliminate every risk. Decision-makers' professional competence therefore cannot match society's lofty expectations. Perhaps it is not surprising that Warner found that the culture of blame induced by public inquiries caused mental health professionals to display 'heightened levels of anxiety... and an increased tendency... to practise defensively'.¹³⁰

According to Tidmarsh, psychiatry should not be resistant to changes in the way the world thinks about disasters.¹³¹ In his view, there is no reason why modern ideas about the causation of hazards cannot apply to psychiatry. Mental health policy should adapt to suit

¹²⁸ G. Szmuckler, 'Homicide Inquiries: What Sense do they Make?' (2000) 24 *Psychiatric Bulletin* 6, at p7.

¹²⁹ J. Peay, 'Clinicians and Inquiries: Demons, Drones or Demigods?' (1997) 9 *International Review of Psychiatry* 171, at pp171, 172. For general discussion of public inquiries in homicide, see J. Peay, *Inquiries After Homicide*, London: Duckworth Publishing, 1996.

¹³⁰ Warner, *supra* n.115, at p6.

¹³¹ D. Tidmarsh, 'Psychiatric Risk, Safety Cultures and Homicide Inquiries' (1997) 8(1) *Journal of Forensic Psychiatry* 138, at p138.

these contemporary mores. Risk Society therefore allows us to assume that mental health practitioners can predict and prevent the harm that patients may pose to themselves or others. In the event of an adverse incident, we are quite justified in asking these decision-makers what went wrong and apportioning blame accordingly. It is submitted that this assumption about mental health decision-making underpinned the broader policy framework which gave rise to the 2007 Act.

So far it seems that the theory of Risk Society maps the development of mental health policy. This applies especially to the general risk of developing a mental illness, which appears to have increased in the modern era. For that reason, risk provides a sensible basis on which to construct and target policies which can respond to the causes of mental illness in contemporary society. In relation to the narrower construction of risk, which considers the likelihood of a person with mental disorder causing harm to himself or others, it appears that Risk Society also explains why mental health policy is now oriented towards regulation and expanding professional responsibility.

Yet, Risk Society is an imperfect model for the 2007 Act. Beck's theory of reflexivity states that the further a society progresses, the greater the risks it faces become. For the Risk Society theory to be a perfect fit for present purposes, we would expect to see the risks associated with mental illness display the same pattern. This is where the parallels end. While the general risk of developing a mental disorder may have increased in the modern era, the same cannot be said about the risk of a person with mental disorder causing harm to himself or others. In fact, the evidence suggests that this risk has remained constant for decades. Patients with mental disorder are no more likely to commit suicide now than they

were twenty years ago. The same applies to the likelihood of a person being killed by someone with a mental disorder.

In their analysis of Home Office crime statistics compiled between 1957 and 1995, Taylor and Gunn found that there was little fluctuation in the number of homicides committed by people with mental disorders during that time.¹³² They argued that the reformulation of national policy towards the care and treatment of twelve or thirteen thousand people based on the actions of approximately forty of them therefore made little sense.¹³³ According to one estimate, the risk that a person with psychosis will kill a stranger is in the region of 1 in 10 million.¹³⁴ Indeed, a person is more likely to be killed by someone *not* suffering from a mental disorder than he is to suffer at the hands of a person with such a diagnosis.¹³⁵ While more recent evidence indicates that there was an overall increase in the number of homicides perpetrated by patients with mental disorders between 1997 and 2007, there were substantial fluctuations in the number of such cases each year (the average was 33 killings a year), making it difficult to discern any long-term trends in the data.¹³⁶ What is clear is that homicides by mentally disordered people are rare and that their rate has in no way kept pace with social progress so as to be consistent with the Risk Society theory. In the case of suicides, the number committed by people with mental disorder is actually *falling*.

¹³² P.J. Taylor and J. Gunn, 'Homicides by People with Mental Illness: Myth and Reality' (1999) 174(1) *British Journal of Psychiatry* 9.

¹³³ *Ibid*, at p10.

¹³⁴ Szmuckler, *supra* n.128, at p6.

¹³⁵ J. Shaw, *et al*, 'Rates of Mental Disorder in People Convicted of Homicide: National Clinical Survey' (2006) 188 *British Journal of Psychiatry* 143.

¹³⁶ The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, *Annual Report: England, Wales and Scotland*, Manchester: the University of Manchester, 2011, at pp25-29.

This is consistent with suicide rates generally, which have shown a steady downward trend generally since 1979.¹³⁷ Between 1997 and 2008, there was a sharp decrease in the number and rate of patient suicides, down from 117.2 *per* 100,000 mental health service users to 98.3.¹³⁸ At a time when the combined hazards of suicide and homicide by the mentally ill were propelling the risk agenda which was so instrumental in shaping the 2007 Act, it seems that they were not as great a problem as policy-makers assumed. The long-term trends have, at best, exhibited a steady decline in the number of incidences or have, at worst, held constant or shown only slight increases.

It seems rather incongruous, then, that the MHA compulsory admission statistics reveal that the number of people detained in hospital has risen year-on-year. Surely if the risks have remained constant or gone into decline, this should be reflected in the admission statistics? At 31st March 2011, 20,938 people were detained under the MHA in England, an increase of five *per cent* on the previous year (16,622).¹³⁹ Between 1998/1999 and 2008/2009, the number of patients formally detained under the MHA increased by an average of 1.5 *per cent* every year in England (except in 2003/2004 when there was a 2.4

¹³⁷ See, R. Jenkins *et al*, *Foresight Mental Capital and Wellbeing Project: Mental Health – Future Challenges*, London: the Government Office for Science, 2008, at para.2.8.1.

¹³⁸ National Confidential Inquiry, *supra* n.136, at pp15, 16.

¹³⁹ Care Quality Commission, *Monitoring the Use of the Mental Health Act in 2010/2011*, 2011, at p16. Available at: http://www.cqc.org.uk/sites/default/files/media/documents/cqc_mha_report_2011_main_final.pdf. Accessed: 17th June 2012. During the year 2010/2011, there were 45,245 detentions under the MHA. While the rate of admissions under section 2 rose by 4.2%, under section 3 it fell by 14.4%. The CQC suggests that the fall in the number of section 3 admissions is attributable to an increase in the number of patients held on CTOs, which carry over from the previous year for statistical purposes. See also, National Health Service and the Office for National Statistics, *In-patients Formally Detained in Hospitals under the Mental Health Act 1983 and Patients Subject to Supervised Community Treatment. Annual Figures, England, 2009/2010*, October 2010. Available at: http://www.ic.nhs.uk/webfiles/publications/005_Mental_Health/inpatientdetmha0910/KP90_final_report.pdf. Accessed: 10th July 2012.

per cent decrease).¹⁴⁰ While this is only a small increase, each year marks the continuation of an upward trend which must surely outstrip the statistical risks of patients causing harm to themselves or other people. This raises an interesting point: if suicide and homicides committed by patients have gone into decline, or remained steady or shown only slight increases, then what accounts for the rising number of admissions to hospital under the MHA? It may be that this incongruity reflects the fact that decision-makers' definitions of what constitutes a risk are much wider than that which is implied by the MHA and its supporting documents. We will return to this point later. For now, the discrepancy might be explained in a more theoretical way: that the risks of suicide and homicide by mentally ill patients do not align with the trends that one would expect to encounter in a Risk Society. In other words, Beck and Giddens' work can apply only up to a point.

We have seen that contemporary mental health policy is illuminated by the Risk Society model, albeit imperfectly. Yet this leaves us with a contextual gap: if the prominence given to the patient's risk to himself and others in the 2007 Act is not a consequence of modernity and a reflection of a society pre-occupied by risk, why else should it be so significant in the policy discourse?

¹⁴⁰ National Health Service and Office for National Statistics, *In-patients Formally Detained in Hospitals under the Mental Health Act 1983 and Patients Subject to Supervised Community Treatment: 1998-1999 to 2008-2009*, October 2009, see Appendix 2, table 1. Available at: http://www.ic.nhs.uk/webfiles/publications/mental%20health/mental%20health%20act/inpatientdetmha0809/KP90_October_2009.pdf. Accessed: 10th July 2012.

3. Governmentality: Plugging the Contextual Gap?

3.1. Risk Society *versus* Governmentality; Realism *versus* Constructivism.

The idea of 'governmentality' is based on the critical theories of Michel Foucault, who argued that the principal objective of those who wield sovereign power in the modern era is government *as an end in itself*. Foucault believed that the government's role was analogous to that of the head of a household: both seek the 'correct manner of managing individuals, goods and wealth' in order to make their fortunes prosper.¹⁴¹ To achieve this, Foucault posited that governments had to have a continuing interest in maintaining 'the welfare of the population, the improvement of its condition, the increase of its wealth, longevity [and] health'.¹⁴² Consequently, the management and control of the population is 'the ultimate end of government'.¹⁴³ Power is therefore exercised according to the priorities of 'biopolitics', which seeks to integrate people 'into systems of efficient and economic controls' by supervising the population to maintain its regularities (and therefore its utility) and discipline those that deviate from them.¹⁴⁴ The term 'governmentality' describes 'a situation in which the state becomes increasingly concerned with the government of population as an end in itself rather than the consolidation of state power'.¹⁴⁵

¹⁴¹ M. Foucault, 'Governmentality' in G. Burchell *et al* (eds.) *The Foucault Effect: Studies in Governmentality* Chicago: University of Chicago Press, 1991, at p92.

¹⁴² *Ibid*, at p100.

¹⁴³ *Ibid*.

¹⁴⁴ M. Foucault, *The Will to Knowledge: The History of Sexuality – Volume 1*, London: Penguin Books, 1998, at pp136, 139.

¹⁴⁵ See Denney, *supra* n.104, at p35.

As in Beck's scholarship, risk is a key component of governmentality, although the concept is interpreted differently. Whereas the Risk Society's 'realism' states that risks 'exist in a hard, material way', governmentality adopts a 'constructivist' approach, which regards risks as social and cultural phenomena to be determined through complex processes of selection and definition.¹⁴⁶ While Risk Society interprets risk according to the principles of natural science, governmentality prefers a social scientific methodology. It offers a particular way of 'representing events in a certain form so they might be made governable in particular ways, with particular techniques and for particular goals'.¹⁴⁷ Owing to this flexibility, Dean believes that risk may have either a quantitative or qualitative character according to the governmentality model. For example, 'epidemiological' risk is concerned with the rates of morbidity and mortality among populations.¹⁴⁸ It has an essentially quantitative character and acts as a calculus of health outcomes. By contrast, 'case management' risk 'concerns the qualitative assessment of individuals... as falling within "at-risk" categories'.¹⁴⁹ This is common in clinical practice wherein certain symptoms will point to the presence (or absence) of disease.¹⁵⁰ Governmentality therefore does not assume a fixed definition of 'risk'; instead, it examines the role that social structures play in

¹⁴⁶ K. Rasborg, "'(World) Risk Society" or "New Rationalities of Risk"? A Critical Discussion of Ulrich Beck's Theory of Reflexive Modernity' (2012) 108(1) *Thesis Eleven* 3, at pp11-12.

¹⁴⁷ M. Dean, *Governmentality: Power and Rule in Modern Society*, 2nd ed., London: SAGE Publications Ltd, 2010, at p206.

¹⁴⁸ *Ibid*, at p218.

¹⁴⁹ *Ibid*.

¹⁵⁰ *Ibid*.

influencing 'subjective' knowledge about risk.¹⁵¹ Here, then, interpretations of risk are much more fluid than those implied by the Risk Society model.

The idea that the concept of risk functions as a technical calculus stems from the discovery of statistical regularities amongst the population. Hacking argues that a key feature of modern societies is their 'fundamentally quantitative feel for nature, how it is and how it ought to be'.¹⁵² Today, we live in a numerical world in which it is possible to calculate the likelihood and magnitude of adverse incidents. This stemmed from the fact that 'an avalanche of numbers' fuelled the development of the modern industrial state.¹⁵³ Hacking points to the collection of medical statistics during the 19th Century, which revealed that the spread of epidemics like cholera was not random but instead conformed to a pattern.¹⁵⁴ This data revealed much about the aetiology of diseases and, as a result, epidemiologists found they could predict with reasonable accuracy their likely impact on the population. In Hacking's view, modern society is no longer shaped by notions of 'determinism' but is rather governed by 'chance', thereby requiring all decision-makers to function probabilistically.¹⁵⁵ The discovery that populations have their own 'regularities' and 'aggregate effects', e.g., rates of death and disease, cycles of scarcity, and levels of mortality,¹⁵⁶ transformed the priorities of the wielders of sovereign power. Indeed, Foucault believed that it was the

¹⁵¹ Mythen, *supra* n.4, at p303.

¹⁵² I. Hacking, *The Taming of Chance*, Cambridge: University of Cambridge Press, 1990, at p5.

¹⁵³ I. Hacking, 'How Should We Do the History of Statistics?' in G. Buchell (eds.) *The Foucault Effect: Studies in Governmentality*, Chicago: University of Chicago Press, 1991, at pp183, 189.

¹⁵⁴ *Ibid*, at p189.

¹⁵⁵ Hacking, *supra* n.152, at p5.

¹⁵⁶ Foucault, *supra* n.144142, at p99.

discovery through statistical data of the population's regularities which provided the rationale for the ensemble of institutions and procedures which we would today recognise as government.¹⁵⁷ By analysing trends in the population, governments can redirect their efforts to maintain the optimum conditions through which they could extract maximum productivity. More significantly, they can also identify those people who, by deviating from the statistical norm, are 'at risk' and therefore present a hazard to the population and, by extension, the government's authority. In this way, imputations of risk are a condition-precedent for the exercise of the supervisory or disciplinary power of government. From the governmentality perspective, risk is an instrument of power which justifies the continuing surveillance and control of a population by the state.

When viewed in this way, it is easy to see how the concept of risk acquires a moral dimension. This is especially true when we consider also that assessments of risk may entail a *qualitative* analysis. If a member of a population does not comply with the construction of regularity, he thereby frustrates the purposes of the governing elite and thus warrants discipline. Consequently, when a person is considered to be 'at risk', this connotes that he has failed to conform in some way. This represents a moral judgement, meaning that considerations of risk have been 'interwoven with ideas of responsibility'.¹⁵⁸ Lupton argues that the concept of risk is now widely used to explain deviations from the norms of

¹⁵⁷ Foucault, *supra* n.141, at pp102-103. Foucault argued that governmentality is characterised by three things: (i) a framework which enables the exercise of a complex form of power which is directed towards the control and management of the population, (ii) that power must achieve pre-eminence over all others, and (iii) an 'administrative' state equipped to complete the objectives of that power.

¹⁵⁸ J.O. Zinn and P. Taylor-Gooby 'The Challenge of (Managing) New Risks' in P. Taylor-Gooby and J.O. Zinn (eds.) *Risk in Social Science*, Oxford: OUP, 2006, at p58.

contemporary Western societies.¹⁵⁹ She contends that imputations of risk are levelled against those people that are culturally positioned on the margins of society.¹⁶⁰ Governmentality values the 'civilised body', i.e., that which is aligned with the white, able-bodied, bourgeois, heterosexual and masculine majority, over 'The Other', which includes women, the working class, non-whites, the disabled, and gays and lesbians.¹⁶¹ Lupton argues that 'The Other' comprises those people who are deemed to be 'prone to emotionality, excessive desire, violence or disarray'.¹⁶² She uses the example of homeless people, who are reconceptualised in modern society as 'dirt' and 'matter out of place that requires removal so as to regain order and purity'.¹⁶³ Such people are socially inferior to the 'civilised body' and considered as morally and physically contaminating.¹⁶⁴ For that reason, they are constructed as "'grotesque bodies"... needful of control surveillance and discipline'.¹⁶⁵ A social system underpinned by governmentality therefore uses risk to demarcate the interests of the 'elite' and to discriminate against those deemed capable of undermining its hegemony. One example of this dynamic is the 'War on Terror', which followed the terrorist attacks of 11th September 2001. Mythen argues that the attacks re-scripted the discourse so as to sanction a variety of measures directed against a section of the population perceived as a risk to national security, e.g., detention without charge or trial

¹⁵⁹ D. Lupton, *Risk*, London: Routledge, 1999, at p3.

¹⁶⁰ *Ibid*, at p49.

¹⁶¹ *Ibid*, at p130.

¹⁶² *Ibid*.

¹⁶³ *Ibid*, at p136.

¹⁶⁴ M. Douglas and A. Wildavsky, *Risk and Culture: An Essay on the Selection of Technological and Environmental Dangers*, Berkley and Los Angeles: University of California Press, 1982, at p47.

¹⁶⁵ *Ibid*, at p147.

and intense forms of surveillance.¹⁶⁶ That risk was inferred from the religious beliefs and ethnic backgrounds of the members of that section of the population, which were deemed to threaten the security of the 'civilised' majority. Here, we can see the influence that public discourse has on interpretations of risk. More importantly, we see how risk becomes deeply bound with notions of morality and 'Otherness' when viewed through the prism of governmentality.

In spite of the emphasis on surveillance and control in the Foucauldian model of risk, there is a degree of overlap with Beck and Giddens' theories. Both schools of thought believe that risk has become a more prominent feature of the modern era. For that reason, Beck and Foucault would presumably agree that modernisation has transformed humanity's understanding of, and interaction with, the world around it. However, whereas Beck argues that society's pre-occupation with risk stems from the increasingly catastrophic hazards which are a by-product of progress, Foucauldian thinkers believe that the concept is an important coefficient which with governments can identify deviance from the norm in a given population. Notwithstanding these distinct theoretical interpretations of the concept, it may be that from a more practical standpoint the consequences of both positions are very similar: both appear to engender a pre-occupation in society with avoiding future hazards, both reshape institutional geography and reorient social policy to adapt to risks, and both seem to prefer a regulatory administrative framework. The key difference is that while Risk Society coheres ostensibly to an objectively-justifiable scientific method of defining risks, governmentality relies on the more subjective influence of prevailing social and political

¹⁶⁶ Mythen, *supra* n.4, at pp309-310.

mores. To what extent can it be said that the construction of a mentally disordered person's risks to himself or others finds its theoretical roots in the ideas of the Foucauldian School?

3.2. Plugging the Gap? Applying Governmentality to the 2007 Act

When one considers the emphasis that policy-makers placed on the risks to patients and the public when they set about reforming the MHA, it is difficult to deny that governmentality offers a convincing prism through which to analyse the 2007 Act. It is arguable that a process similar to that which Mythen identifies in the War on Terror took place in mental health policy: policy-makers successfully re-scripted the discourse in order to justify legislative reforms which have since made it easier to admit people with mental disorder to hospital on a compulsory basis. The discourse of New Medicalism therefore values control of people with mental illness by practitioners who refer to factors which are deemed liable to increase their risks. What these factors may be is unclear but reasoning by analogy from Mythen's example would suggest that they may have little causal potency in practice. According to Castel, this transformation of psychiatric practice is consistent with the broader trends exhibited by medicine in general. He argues that medical practice has shifted 'towards the point where the multiplications of systems of health checks [have made] the individualised interview between practitioner and client almost dispensable'.¹⁶⁷ Clinical judgment is now less important where an expanding knowledge base allows decision-makers to select from a range of abstract factors those which are liable to produce risk.¹⁶⁸ This actuarial approach has become a common feature of psychiatric practice of late.

¹⁶⁷ R. Castel, 'From Dangerousness to Risk' in G. Burchell *et al* (eds.), *The Foucault Effect: Studies in Governmentality*, London: Sage, 1996, at pp281-282.

¹⁶⁸ *Ibid.*

Here, risk assessment focuses on those factors shown to be ‘statistically associated with increased risk in large samples of people’, resulting in an overall score which serves as an indicator of presumed risk over a specific time period.¹⁶⁹ As a result, medical practices are predominantly *administrative* processes in which doctors plan out trajectories and ensure that human profiles match up to them.¹⁷⁰ This ‘de-personalisation’ of clinical practice has been particularly evident in psychiatry. The upshot, according to Castel, is that it is no longer necessary for patients to manifest symptoms of dangerousness; instead, it is enough for them to display whatever characteristics have been reinterpreted as risk factors.¹⁷¹ In this way, psychiatrists and allied professionals can complete the objectives of governmentality. It is easy to see why Foucault believed that the ultimate purpose of psychiatry was the ‘supervision of normality’.¹⁷² How far does the 2007 Act continue in this tradition?

Denney argues that as a result of the risk agenda, ‘increased surveillance and attempts to predict dangerous and violent behaviour in the mentally ill’ are now essential requirements of the mental health system.¹⁷³ Yet, why this should be the case is not clear. We know that the risks of people with mental disorders harming either themselves or others are low. Indeed, they have remained consistent over the course of time, suggesting that there is no causal relationship between social progress and an increase in these risks. For that reason, we must assume that there is another explanation for the keen emphasis that policy-makers placed on these narrower risks when drafting the 2007 Act. The answer,

¹⁶⁹ Best Practice Guide, *supra* n.103, at p18.

¹⁷⁰ Castel, *supra* n.167, at p295.

¹⁷¹ *Ibid.*

¹⁷² M. Foucault, *Discipline and Punish: the Birth of the Prison*, Penguin Books, 1991, at p296.

¹⁷³ Denney, *supra* n.104, at p114.

plainly, is that they were subject to what we might call a Foucauldian impulse to assert control over a section of the population that they had recast as 'deviant'. Policy-makers were adamant that considerations of risk should always take precedence in mental health decision-making. They identified an ineluctable relationship between mental illness and suicide and violence, believing that it warranted coercive oversight *notwithstanding* evidence which suggested that the link in fact rarely materialised. Consequently, people with mental disorders were implicitly seen as a challenge to the 'civilised body'. They are therefore a category extension of Lupton's notion of 'Otherness'; a group that policy-makers considered needful of control and discipline.

Mindful of this, it is perhaps unsurprising that the reforms of the MHA took the shape that they did. We already know that the 2007 Act, *inter alia*, simplified the definition of 'mental disorder',¹⁷⁴ thereby removing the 1983 Act's rigid legalistic categorisations; abolished the 'treatability test',¹⁷⁵ requiring only that treatment for mental disorders be 'appropriate'; and broadened the range of professionals who could engage the compulsory powers,¹⁷⁶ removing the separation of powers that existed between representatives of the clinical and social models. The central theme of the 2007 Act made it easier to exert control over risky patients with mental disorders using the compulsory powers. What might amount to a risk is a matter for decision-makers; there is no definition of the concept in the MHA, suggesting that doctors and allied professionals can take their cue from the discourse in which the legislation was enveloped. Indeed, this is a particular necessity when one

¹⁷⁴ 2007 Act, s.1(2).

¹⁷⁵ 2007 Act, s.4.

¹⁷⁶ 2007 Act, ss.9-21.

considers that the judgment of riskiness is only partially conducted in medical terms; according to Rose, matters such as employment, family, alcohol consumption, coping skills, and the patient's ability to cook, shop and manage money have become absorbed within the mental health practitioner's discretionary competence.¹⁷⁷ In this way, decision-makers have been co-opted into completing the objectives of policy-makers by facilitating greater control over patients with mental disorders. It is on this theoretical basis that the narrower concept of risk to self or others must be understood in the context of the 2007 Act.

4. Conclusions

It is difficult to deny that risk was instrumental in shaping the policy behind the 2007 Act. The question is: why? Was the 'rise of risk' in mental health policy simply part of a broader pre-occupation with risk in modern society? Or did risk gain prominence because it offers a handy device with which to exert control over a 'deviant' section of the population? This chapter has shown that to some extent it was both.

First, Beck and Giddens' Risk Society theories posit that society manufactures potentially catastrophic hazards as a by-product of its progress. As a result, the priorities of its social policy are transformed to prevent adverse incidents occurring in the future. It is true that modernity has had particular consequences for health: around a quarter of the population of the United Kingdom is now at risk of developing some form of mental disorder, which has further implications for public spending and service provision. Policy- and decision-makers have also recognised that timely interventions can reduce the risk of mental illness by

¹⁷⁷ N. Rose, 'Governing Risky Individuals: the Role of Psychiatry in New Regimes of Control' (1999) 5(2) *Psychiatry, Psychology and Law* 177, at p185.

tackling the social and environmental factors that render people susceptible to mental illness. Here we see both a decline in traditional or natural interpretations of adverse events and a growing faith in the capabilities of human intervention. This explains why mental health policy has placed greater emphasis on preventive strategies in recent years. It also provides a context for the growth of regulatory oversight and professional responsibility (and defensiveness) since the 1983 Act.

Yet, Risk Society does not entirely account for the amplification in public discourse of anxieties about mentally disordered patients' risks to themselves or others. In order for the Risk Society thesis to apply, there would have to be evidence of an *increase* in the risk of patients killing themselves or harming others as society has progressed in the modern era. In fact, the evidence suggests that the opposite is true: the risks have either declined or at least stayed constant. Yet the number of people subject to the MHA's compulsory powers continues to rise. So why was risk the policy driver of the 2007 Act? We must assume that policy-makers deemed the risks posed by mentally disordered patients to be so great that it warranted special control. Consequently, their emphasis on this kind of risk adheres closely to the Foucauldian construct of governmentality. By making it easier for decision-makers to deploy the MHA's compulsory powers, the 2007 Act notionally facilitates tighter control of those 'deviant' sections that fail to conform to the rest of the population's regularities. The Act uses risk as a way to measure the likelihood that a person with mental illness will threaten the norms of the 'civilised body'. In other words, risk is an instrument of social control in contemporary mental health law and policy.

The remainder of this thesis will interpret the 2007 Act generally as a product of a modernised society pre-occupied by risks. It will assume that the specific risk of the patient

causing harm to himself or others traces its roots to the Foucauldian notions of discipline and control. In the next chapter, we will consider the challenges that the concept of risk may pose to legal certainty, professional decision-making and patients' liberties.

Chapter 3

Immediately Befogged: The Problem with Risk

1. Introductory

According to Niklas Luhmann, those who seek definitions of ‘risk’ find themselves ‘immediately befogged’.¹ It is true that risk is a tricky concept. On one hand, it is ‘a very loose term in everyday parlance’;² on the other, it is a calculation of the likelihood of an adverse outcome. While this breeds confusion, it also reflects how expressive the word is. Yet, because risk is embedded in the mechanics of the Mental Health Act (‘MHA’), this lack of certainty is also problematic. The courts emphasise that if a person is to be deprived of his liberty, the legal basis must be clearly defined.³ This chapter argues that uncertainty about risk poses a problem from a legal point of view: how can the MHA achieve legal certainty if there is no agreement about the meaning of one of its fundamental concepts?

We start by discussing risk’s broad semantic range, positing that this makes it even harder to establish what ‘risk’ means when it is applied in a particular legal context. This chapter will show that risk is fundamental to the functioning of the MHA; a patient with

¹ N. Luhmann, *Risk: A Sociological Theory*, London: Aldine Transaction, 2007, at p6.

² D. Lupton, *Risk*, London: Routledge, 1999, at p9.

³ See, e.g., *Re S-C (Mental Patient: Habeas Corpus)* [1996] QB 599, *per* Sir Thomas Bingham MR at 603: ‘Action may only be taken if there is clear evidence that the medical condition of a patient justifies such action, and there are detailed rules prescribing the classes of person who may apply to a hospital to admit and detain a mentally disordered person’. See also, *Kawka v Poland*, ECtHR, Application No 25874/94, Judgment of 9 January 2001, at para.49: ‘...where deprivation of liberty is concerned, it is particularly important that the general principle of legal certainty is satisfied. It is therefore essential that the conditions for deprivation of liberty under domestic law should be clearly defined and that the law itself be foreseeable in its application...’

mental disorder who is deemed to pose a risk to himself or other people faces compulsory admission to, or treatment in, hospital. Risk therefore has a transformative effect on a patient's engagement with mental health services. Yet, despite its significance, we will see that the 2007 Act neither defines the concept nor delimits its scope. The courts too have not specified what risk means in mental health law, preferring not to intervene in the clinical domain. This means that there is no clearly prescribed threshold for compulsion in the MHA, making it difficult for patients to predict the nature and extent of their interaction with mental health services. *This* is the problem with risk to which the title of this chapter refers. We will argue that the lack of a definition and delimitation of risk has created a kind of 'risk exceptionalism', whereby the law has no real function in monitoring decision-makers' assessments and interpretations of risk. This allows practitioners to use the language of risk to legitimise decisions and thereby circumvent the courts' oversight. While this may complete the objectives of New Medicalism by maximising clinical discretion, it also serves to undermine the purpose of the MHA's legal protections.

This chapter relies on a technical and 'black letter' analysis of the law and will draw on the MHA and case law. Through this, it will show that the concept of risk is antithetical to legal certainty. First, we must ask whether there is a general definition of 'risk' which might help to clarify the concept's specific application to the MHA.

2. Is There a General Definition of 'Risk'?

Defining 'risk' is not a straightforward task. Indeed, the multi-faceted nature of the concept makes the quest for a general definition rather quixotic. This uncertainty is undoubtedly a consequence of the word's wide usage and a lack of agreement about its

etymology. 'Risk' may originate from the seventeenth century French word '*risque*', or the Italian '*risco*', which is itself of uncertain origin.⁴ Alternatively, it may have developed from the Arabic '*risq*' ('riches or good fortune'), Greek '*rhiza*' ('cliff'), or Latin '*resegare*' ('to cut off short').⁵ There is evidence to suggest that the word first appeared among Western explorers in the Age of Discovery to refer to the hazards attendant on sailing through uncharted waters.⁶ Others argue that it developed from gambling,⁷ or that it first emerged as a principle of the laws of maritime insurance.⁸ In any event, the first recorded general definition of 'risk' ('hazard, danger; exposure to mischance or peril') dates from 1661.⁹ According to the Oxford English Dictionary, 'risk' became a feature of legal language by the eighteenth century, although it was not until the twentieth century that the word would apply to a person 'who is considered a liability or danger'.¹⁰ During this time, words like 'analysis' and 'assessment' were first coupled with 'risk', giving rise to the lexicography with which we are familiar today.¹¹

⁴ Oxford English Dictionary, 2nd edition, 1989.

⁵ I. Wilkinson, *Risk, Vulnerability and Everyday Life*, London: Routledge, 2010, at p17.

⁶ A. Giddens, 'Risk Society: the Context of British Politics' in J. Franklin (ed.), *The Politics of Risk Society*, Malden, Massachusetts: Polity Press, 1998, at p27.

⁷ M. Douglas, *Risk and Blame: Essays in Cultural Theory*, London: Routledge, 1992, at pp14-15.

⁸ Wilkinson, *supra* n.5, at p17.

⁹ OED, *supra* n.4.

¹⁰ *Ibid.*

¹¹ *Ibid.*

In the modern era, the dictionary definition of 'risk' ('exposure to the chance of injury or loss, a hazard or dangerous chance')¹² offers a reasonably fixed meaning, though it still fails to capture the enormous range of the word's colloquial usage. Over time, the application of risk has changed to suit contemporary circumstances, conferring a degree of elasticity on the concept's semantic scope. According to Alaszewski, the word 'risk' is now the 'tip of an iceberg of related words or terms', which include: 'hazard', 'harm', 'safety', 'dangerousness', 'vulnerability', and 'blame'.¹³ It is true that these terms are synonymous with 'risk' today, although this does little to clarify what the word means in the abstract.¹⁴ Indeed, Alaszewski seems to suggest that it may make this task even harder. The 'risk iceberg' comprises 'an interrelated set of words that are linked around issues of chance and outcome'. For that reason, there is some interchangeability between these words 'and a degree of circularity in their definitions'.¹⁵

Colloquially, 'risk' is capable of applying in various parts of speech: as a noun ('there is a risk of rain today'), verb ('I risk losing the match'), adjective ('a risky endeavour') or adverb ('he behaves too riskily'). It can also form idiomatic phrases, for example, 'she is running a risk' or 'I risked life and limb'. In this way, it seems that risk's everyday usage applies to vague notions of chance, danger and uncertainty. According to Adams, modern human

¹² Dictionary.com, 'Risk' in *Dictionary.com Unabridged*, Random House Inc. Available: <http://dictionary.reference.com>. Accessed: 7th December 2009.

¹³ A. Alaszewski, 'Risk in Modern Society' in A. Alaszewski *et al* (eds.) *Risk, Health and Welfare: Policies, Strategies and Practice*, Buckingham: Open University Press, 1998, at p10.

¹⁴ According to Thesaurus.com, 'risk' is synonymous with 'accident', 'contingency', 'danger', 'exposedness', 'exposure', 'fortuity', 'fortune', 'gamble', 'hazard', 'jeopardy', 'liability', 'luck', 'opportunity', 'peril', 'possibility', 'prospect', 'shot in the dark', 'uncertainty', 'venture', and 'wager'. Available at: <http://thesaurus.reference.com/>. Accessed: 9th December 2009.

¹⁵ Alaszewski, *supra* n.13, at p13.

beings can be described as *Homo aleatorius*, or 'risk-taking man', because of their pre-occupation with risk.¹⁶ Perhaps as a consequence of this, he explains that the English language is 'littered with aphorisms extolling the virtues of risk'; for example, phrases like 'nothing ventured, nothing gained' and 'no risk, no reward' are common in spoken and written exchanges.¹⁷ The ubiquity of the term in conversational discourse reflects our tendency to interpret the world around us through the prism of risk.

'Risk' also has a more technical character. According to the Royal Society, risk can be expressed in mathematical terms, i.e., it is the quantitative chance of a defined hazard occurring.¹⁸ This encapsulates both a 'probabilistic measure' of the likelihood that the primary event will occur and a 'measure of the consequences of that event'.¹⁹ When assessing risk, one must therefore ask (i) how likely is X to happen, and (ii) how serious will the consequences of X be if it does happen? As far as the second consideration is concerned, Saaty points out that this will involve a wider assessment of the character of the potential loss, its extent in terms of intensity and diffusion, and its timing.²⁰ Yet decision-making geared towards hazard prevention is not the only technical usage of risk. In legal

¹⁶ J. Adams, *Risk*, London: UCL Press, 1995, at pp1, 16. See also, P. Slovic, 'Perception of Risk' (1987) 236 *Science* 280, who explains, at p280, that the key to human survival has been the ability to codify and learn from past experience.

¹⁷ *Ibid*, at p17.

¹⁸ F. Warner, *et al*, *Risk: Analysis, Perception and Management: Report of a Royal Society Study Group*, London: Royal Society, 1992, at p4. The Royal Society also defined 'hazard' ('a situation that in particular circumstances could lead to harm'), 'harm' ('loss to a human being consequent on damage'), and 'damage' ('loss of inherent quality suffered by an entity').

¹⁹ *Ibid*.

²⁰ T.L. Saaty, 'Risk – Its Priority and Probability: the Analytic Hierarchy Process' (1987) 7(2) *Risk Analysis* 159, at p163.

theory, 'risk' can describe 'circumstances [that] may (or, importantly, may not) turn out in a way that we do not wish for'.²¹ This construction is particularly relevant in the law of tort, where a defendant's failure to exercise reasonable care to avoid risks amounts to a breach of duty in negligence.²² In still other uses, 'risk' may refer to attributes which 'differentiate the mortality or morbidity experience between groups of individuals with or without the attribute'.²³ For example, it is a well-known fact that smoking is a risk to health; therefore, those patients who smoke are deemed more likely to experience adverse health events than those who do not. It is clear that even when it is employed in technical contexts, there are many sides to the concept of risk.

As a consequence of this flexibility, it is difficult to know what the natural or ordinary meaning of 'risk' is; indeed, it is doubtful that it even has one. Douglas argues that the concept's flexibility reflects the influence that socio-cultural factors have on it.²⁴ In her view, the term's enormous utility comes from 'its universalising terminology, its abstractness, its power of condescension, its scientificity, its connection with objective analysis'.²⁵ In other words, 'risk' so lacks definition that it is capable of meaning many things to different people. What begins to emerge is a portrait of a complex concept which can apply so broadly that it

²¹ J. Steele, *Risks and Legal Theory*, Oxford: Hart Publishing, 2004, at p6.

²² See, e.g., *Glasgow Corporation v Muir* [1943] AC 448, HL; *Nettleship v Weston* [1971] 3 All ER 581, CA.

²³ M.V. Hayes, 'On the Epistemology of Risk: Language, Logic and Social Science' (1992) 35(4) *Social Science and Medicine* 401, at p403.

²⁴ Douglas, *supra* n.7, at pp14-15. Interestingly, Douglas points out that while Japanese has words for 'danger', 'damage' and 'harm', there is no word that can translate directly into 'risk'. She argues that this is attributable to socio-cultural differences between the West and Japan.

²⁵ *Ibid.*

defies objective explication. This raises a key problem: if there is no agreement about the meaning of 'risk' in general terms, how can the concept apply with any certainty in more specific contexts? This is particularly pressing in mental health law: to what extent can such an ill-defined concept achieve compatibility with the demands of legal certainty?

For now, it is enough to recognise that 'risk' has two universal characteristics. First, it is essentially a negative thing. In the past, it was value-neutral; a dispassionate probabilistic device which decision-makers applied to overcome uncertainty.²⁶ Since then, Douglas argues that the language of risk has become 'a specialised lexical register for... talk about... undesirable outcomes'.²⁷ In both colloquial and technical contexts, conversations about risk share a common theme of seeking to avoid adverse consequences. Secondly, 'risk' is a contingent thing. Implicit in any discussion of risk is the assumption that steps can be taken to avoid or reduce the likelihood of a given hazard.²⁸ A situation of risk therefore arises in circumstances that are necessarily contingent on a decision-maker's choice. While characterising risk as a negative and contingent thing falls short of a general definition, we can discern from this the themes that underpin its application in colloquial and technical contexts (and everything in between). Yet this tells us little about how decision-makers might understand *substantive* risks in mental health law. In light of the fact that risk is so deeply embedded in the mechanics of the MHA, this is troubling.

²⁶ See, e.g., Douglas, *supra* n.7, at p23; D. Denney, *Risk and Society*, London: SAGE, 2005, at p9; L.A. Jacobs, 'An Analysis of the Concept of Risk' (2000) 23(1) *Cancer Nursing* 12, at p12.

²⁷ Douglas, *supra* n.7, at p24. See also, J. Gabe, 'Health, Medicine and Risk: the Need for a Sociological Approach' in J. Gabe (ed.), *Medicine, Health and Risk*, Oxford: Blackwell, 1995.

²⁸ Luhmann, *supra* n.1, at p16. Luhmann said that in any definition of risk the key requirement is that the injury, loss or damage should be avoidable.

3. The Mechanics of Risk

3.1. Risk as the Trigger to Compulsion under the MHA

Risk is an integral feature of the MHA. The only way that a mentally disordered person's compulsory admission to and continuing detention in hospital can be legitimate for the purposes of the Act is where he is admitted for the sake of his health or safety or for the protection of other people. Risk is therefore the key to the compulsory powers. This is illustrated by sections 2 and 3 of the Act, which provide the legal bases for patients' admission for assessment and treatment respectively. An application under either section may be made by the patient's nearest relative²⁹ or by an approved mental health professional (AMHP) and it must be addressed to the managers of the hospital to which admission is sought.³⁰ Section 2 provides that a patient may be admitted to a hospital for assessment and detained there for a period not exceeding twenty-eight days where two registered medical practitioners certify in writing that the patient:

- (a) is suffering from mental disorder of a nature or degree which warrants his detention in a hospital for assessment for at least a limited period; and
- (b) ought to be so detained *in the interests of his health or safety or with a view to the protection of other persons*.³¹

It is thus a condition-precendent of a patient's admission that the clinical team be satisfied that his mental disorder is of such a nature or degree³² that he poses a risk either to himself

²⁹ MHA, ss.26-30.

³⁰ MHA, ss.11(1) and (2).

³¹ MHA, s.2(2). Emphasis added.

or others. The same formula appears under section 3, albeit with slightly different wording. Here, a patient may be admitted to hospital for treatment and be detained there for up to six months³³ where two medical practitioners certify in writing that:

- (a) the patient is suffering from a mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in hospital, and
- (b) [repealed by the 2007 Act]³⁴
- (c) it is *necessary for the health or safety of the patient or for the protection of other persons* that he should receive such treatment and it cannot be provided unless he is detained under this section, and
- (d) appropriate medical treatment is available for him.³⁵

This time, the medical practitioners must be satisfied that the patient's risk profile is such that it is *necessary* to detain him in hospital for the purposes of administering medical treatment. This suggests that the threshold for action is higher under section 3, which is perhaps unsurprising given that it is the gateway to a situation in which compulsory medical treatment can be administered to the patient without his consent.³⁶ In any event, the references to the patient's health or safety and the protection of others – the 'risk formula'

³² The phrase 'nature or degree' does not have to be read conjunctively, see R v Mental Health Review Tribunal for South Thames Region, ex parte Smith (1999) 47 BMLR 104; R (on the application of the Secretary of State for the Home Department) v Mental Health Review Tribunal [2003] EWHC 2846 (Admin).

³³ MHA, s.20(1). The six-month timeframe may be renewed for a further six months in the first instance and annually thereafter (see MHA, s.20(2)).

³⁴ MHA, s.3(2)(b) contained the former 'treatability' test.

³⁵ MHA, s.3(2) (as amended by MHA 2007, s.4(2)(b)). Emphasis added.

³⁶ MHA, s.63. See also P. Bartlett and R. Sandland, *Mental Health Law, Policy and Practice*, 2nd ed., Oxford: OUP, 2003, who speculate, at p150, that the use of the term 'necessary' in section 3 contrasts with 'ought' in section 2, suggesting that the former entails 'a slightly higher threshold'.

– are repeated throughout the MHA, governing admission,³⁷ guardianship,³⁸ leave of absence,³⁹ supervised community treatment,⁴⁰ renewal of detention,⁴¹ extension of community treatment periods,⁴² restriction orders,⁴³ the power of tribunals to order the discharge of the patient,⁴⁴ and police powers to remove to places of safety mentally disordered people found in public.⁴⁵ The Act assumes that the assessment of risk is the second stage in a linear decision-making process which has a transformative effect on the nature and extent of a patient’s interaction with mental health services.⁴⁶ This is illustrated by *Figure 3.1*:

³⁷ MHA, ss.2(2)(b); 3(2)(c); and 5(4)(a).

³⁸ MHA, s.7(2)(b).

³⁹ MHA, s.17(1) and (4).

⁴⁰ MHA, ss.17A-17G.

⁴¹ MHA, s.20.

⁴² MHA, s.20A.

⁴³ MHA, ss.41 and 42.

⁴⁴ MHA, s.72. The MHRT shall direct the discharge of a patient detained under ss.2 or 3 where it is *not* satisfied that, *inter alia*, his detention is justified in the interests of, or necessary for, the patient’s health or safety or for the protection of others respectively.

⁴⁵ MHA, s.136.

⁴⁶ MHA, s.131(1) makes it clear that nothing in the MHA shall be construed as preventing a patient who requires treatment for mental disorder from receiving it informally.

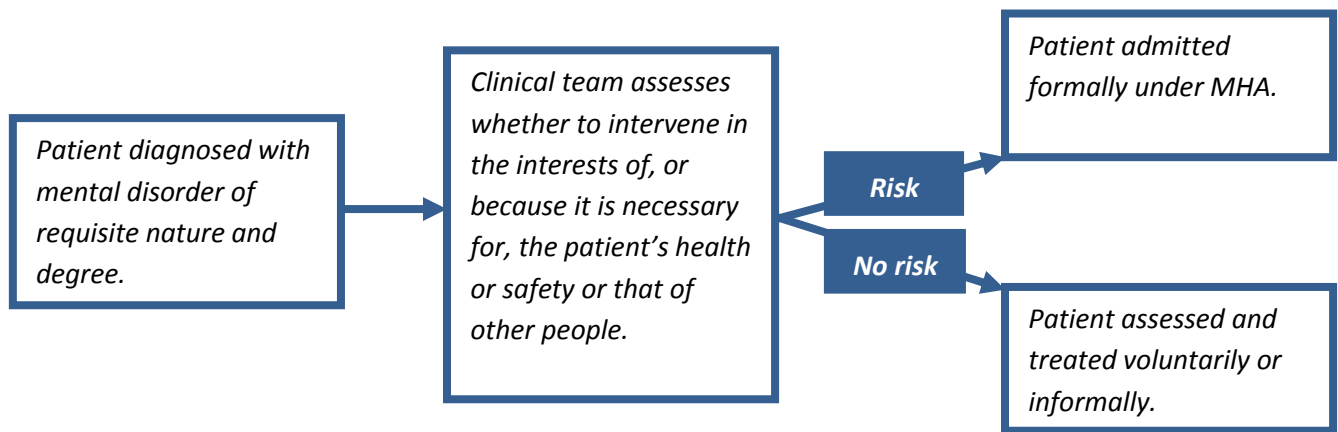


Figure 3.1. Diagram illustrating the mechanics of risk in the MHA's decision-making process.

There is no doubt then that the concept of risk is at the root of the MHA's compulsory powers. This point was emphasised in R (on the application of B) v S and Others,⁴⁷ where Lord Phillips said that the MHA's coercive powers are a necessary means of ensuring that patients with mental disorders receive medical treatment for their conditions. This in turn is justified because compulsory treatment is necessary for the health or safety of the patient or for the protection of others.⁴⁸ In this case, the Court of Appeal agreed with the first instance judge, who had held that the patient's capacity is not a critical factor in determining whether treatment can be administered without consent pursuant to section 58. It is clear that a patient's level of risk, and not his capacity, is the fulcrum on which the entire functioning of the MHA's compulsory powers turns. It is also clear that the MHA regards a patient with mental disorder who poses a risk to himself or others in wholly negative terms. This means that the MHA makes no allowance for positive risk-taking,⁴⁹ nor does it take account of the iatrogenic risks that flow from compulsory medical

⁴⁷ [2006] EWCA Civ 28.

⁴⁸ *Ibid*, at para.43.

⁴⁹ 'Positive risk-taking' is a legitimate therapeutic strategy by which clinicians accept that it is impossible to avoid risks in every case. Consequently, they *manage* patients' risks without resorting to civil commitment. This approach requires decision-makers to take risks with some patients who might ordinarily be admitted under the MHA. See, e.g., F. Holloway, 'The Assessment and Management of Risk in Psychiatry: Can We Do Better?' (1997) 21 *Psychiatric Bulletin* 283; S. Morgan, 'Risk-making or Risk-taking?' (2000) 101 *Openmind: The Mental Health Magazine* 16.

intervention.⁵⁰ The MHA therefore possesses a paternalistic character which uses risk to justify coercion and implicitly diminishes the importance of the patient's autonomy.

3.2. The Deprivation of Liberty Safeguards ('DOLS'): Intensifying the MHA's Focus on Risk.

The introduction of the Deprivation of Liberty Safeguards ('DOLS') has intensified the MHA's emphasis on risk. Inserted into the Mental Capacity Act ('MCA') 2005⁵¹ by the 2007 Act,⁵² the Safeguards are designed to close the gap between voluntary admission under the common law on one hand and formal admission subject to the MHA on the other. In doing so, they incidentally reaffirm that risk is the principal trigger for compulsion under the MHA.

3.2.1. The *Bournewood* Gap

The so-called 'Bournewood gap' was identified in R v Bournewood Community and Mental Health NHS Trust, ex parte L,⁵³ which concerned an adult patient with severe autism who lacked the capacity to consent to medical treatment. The patient, 'L', was transferred to hospital after he became agitated and exhibited self-injurious behaviour at a day centre. The consultant in charge of L's care decided that it was in his best interests that he be admitted to hospital informally pursuant to section 131 of the MHA. Because L was

⁵⁰ Admitting a patient under the MHA produces 'iatrogenic risks', i.e., additional risks contingent on compulsory care and treatment. For example, there are risks from medication, stigma, and the disempowering nature of mental health services. See, e.g., J. Langan, 'Assessing Risk in Mental Health' in P. Parsloe (ed.) *Risk Assessment in Social Care and Social Work*, London: Jessica Kingsley Publishers, 1999, p153; J. Langan and V. Lindow, 'Risk and Listening' (2000) 101 *Openmind: the Mental Health Magazine* 14.

⁵¹ Sections 4A and 4B, and Schedules A1 and 1A.

⁵² Section 50 and Schedules 7, 8 and 9.

⁵³ [1999] 1 AC 458, HL.

compliant and made no attempt to leave the hospital, the consultant thought that compulsory admission under Part II of the MHA was unnecessary. We can infer from this that L's risk profile was not grave enough to engage the MHA. Consequently, L was kept on an unlocked ward, but if he made any attempt to leave he would be sectioned. He was therefore in something of a legal 'no man's land'.⁵⁴ After the Court of Appeal held that L's informal admission was unlawful, the respondent NHS Trust appealed to the House of Lords, which had to address two questions: (i) was L detained against his will, and (ii) if so, did the hospital have lawful authority to justify L's detention?⁵⁵ The House of Lords held that the only basis on which a hospital could lawfully admit a patient with mental disorder who lacks capacity but does not manifest any objection to his admission is on the basis of the common law doctrine of necessity.⁵⁶ In L's case, their Lordships decided by a bare majority that he had not been detained because he had been held on an unlocked ward and was notionally free to leave at any time. In any event, because the NHS Trust had acted in accordance with L's best interests in an urgent intervention justified by the doctrine of necessity, there would have been a legal basis for his detention at common law. Speaking for the majority, Lord Goff said that it was 'plainly the statutory intention that...patients [admitted informally and lacking capacity] would indeed be cared for, and [would] receive such treatment for their condition as might be prescribed for them in their best interests.'⁵⁷ It would therefore

⁵⁴ P. Bartlett, 'Informal Admissions and Deprivation of Liberty under the Mental Capacity Act 2005' in L. Gostin *et al* (eds.), *Principles of Mental Health Law and Policy*, Oxford: OUP, 2010, at p386.

⁵⁵ See M.A. Jones, 'Detaining Adults who Lack Capacity' (2007) 4 *Journal of Professional Negligence* 238.

⁵⁶ See, e.g., *T v T* [1988] 1 All ER 613; *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1; *Re A (Medical Treatment: Sterilisation)* [1999] 53 BMLR 66; *Airedale NHS Trust v Bland* [1993] AC 789.

⁵⁷ *Ex parte L*, *per* Lord Goff at 485.

defeat the purpose of the MHA and the common law if patients in L's position were falsely imprisoned without lawful authority.

The Bournewood case suggests that the common law still has a residual role in play in plugging gaps in the MHA regime. Yet the significance of its *ratio* was diminished somewhat when L's case reached the European Court of Human Rights (ECtHR) in HL v United Kingdom.⁵⁸ Here, the applicant – now referred to as 'HL' – relied on Articles 5(1) and 5(4) of the European Convention on Human Rights (ECHR) to argue that his informal detention in hospital had contravened his right to liberty. The ECtHR agreed. First, it found that HL had been 'deprived of his liberty' for the purposes of Article 5(1) because the healthcare professionals had exercised 'complete and effective control' over his care and movements at all times, meaning that he was subject to 'continuous supervision and was not free to leave [the hospital]'.⁵⁹ The ECtHR adopted the reasoning from Lord Steyn's dissenting speech in the House of Lords, in which His Lordship had said that the suggestion that L was free to go was 'a fairy tale'.⁶⁰ Secondly, the ECtHR said that HL's deprivation of liberty was not 'in accordance with a procedure prescribed by law' for the purposes of Article 5(1)(e). There was therefore a breach of Article 5(1) because there is a 'striking...lack of any fixed procedural rules by which the admission and detention of compliant incapacitated persons is conducted' under the English common law.⁶¹ The Court pointed to the 'significant contrast' between the 'dearth' of regulation in respect of patients in HL's position on one hand and the 'extensive network of safeguards' which applies to psychiatric committals

⁵⁸ (2005) 40 EHRR 32.

⁵⁹ HL v UK, at para.91.

⁶⁰ Ex parte L, per Lord Steyn (dissenting) at 495.

⁶¹ HL v UK, at paras.119-20.

under the MHA on the other.⁶² It concluded that in HL's case there was nothing to prevent decision-makers from taking arbitrary and therefore unlawful decisions to deprive a patient of his liberty. Finally, Article 5(4) ECHR requires that a speedy procedure be in place so a person deprived of his liberty can challenge the lawfulness of his detention in court. The ECtHR said that the means by which HL could have brought such proceedings – the writ of *habeas corpus* and judicial review – placed the bar 'so high as effectively to exclude any adequate examination of the merits of the clinical views as to the persistence of mental illness justifying detention.'⁶³ For that reason, there had also been a violation of Article 5(4) ECHR in HL's case.

The ECtHR's decision in HL v United Kingdom had serious policy implications: any public hospital or care home which held patients in Bournewood-style circumstances was effectively responsible for continuing violations of Article 5. To address this, the Department of Health launched a consultation exercise to establish how it might close the Bournewood gap.⁶⁴ It opted for a framework that would be conceptually distinct from the MHA. According to a Briefing Paper published in 2006, the Department of Health anticipated that the new procedure would not apply in circumstances where the MHA could be used,⁶⁵ thereby reserving the compulsory powers for patients who satisfy the risk formula. The proposed framework would provide legal safeguards for vulnerable people deprived of their

⁶² *Ibid.*

⁶³ HL v UK, at para.139.

⁶⁴ Department of Health, 'Bournewood Consultation: The Approach to be Taken in Response to the Judgment of the European Court of Human Rights in the "Bournewood" Case', March 2005.

⁶⁵ Department of Health, 'Bournewood Briefing Sheet', Gateway Reference: 6794, June 2006, at p2.

liberty in hospital who lack capacity but do not object to their detention.⁶⁶ This new regime came into effect on 1st April 2009.

3.2.2. The DOLS Framework

The mechanics of the DOLS are complex and confusing. According to the DOLS Code of Practice, the Safeguards cannot apply to people while they are detained in hospital under the MHA.⁶⁷ While that is true, the link between DOLS and the MHA is less straightforward than that. Indeed, various commentators have condemned the drafting of the DOLS framework as 'hideous'⁶⁸ and 'overcomplicated'.⁶⁹ Generally, the MCA 2005 does not authorise any person to deprive any other person of his liberty,⁷⁰ thereby establishing a presumption that patients within the purview of that legislation cannot be detained in hospital. This clearly contrasts with the MHA. The only way in which a person *can* deprive another person of his liberty under the provisions of the MCA 2005 is either where he is giving effect to a relevant court order⁷¹ or the deprivation of liberty is authorised by the DOLS under Schedule A1.⁷² In the latter case, a deprivation of liberty will only be authorised

⁶⁶ *Ibid*, at p1.

⁶⁷ Ministry of Justice, *Mental Capacity Act 2005 – Deprivation of Liberty Safeguards: Code of Practice to Supplement the Main Mental Capacity Act 2005 Code of Practice*, London: TSO, 2008, at para.1.11.

⁶⁸ Bartlett, *supra* n.54, at p392.

⁶⁹ L. Series, 'Deprivation of Liberty Safeguards: a Haphazard Affairs', *The Guardian*, Monday 2nd April 2012. Available at: <http://www.guardian.co.uk/social-care-network/2012/apr/02/deprivation-liberty-safeguards-improvements>. Accessed: 28th January 2013.

⁷⁰ MCA 2005, s.4A(1).

⁷¹ MCA 2005, ss.4A(2)(a), 4A(3), 4(4) and 16(2)(a). Section 4B of the MCA 2005 also creates a legal basis on which one person can deprive another person of his liberty if (i) he is seeking a decision in relation to any relevant issue from the court, and (ii) the deprivation is necessary in order to give life-sustaining treatment to the other person.

⁷² MCA 2005, ss.4A(2)(a) and 4A(5).

where (i) a person is detained in a hospital or care home for the purpose of receiving care or treatment in circumstances which amount to a deprivation of liberty, (ii) there is a standard or urgent authorisation in force, and (iii) that authorisation applies to the detained person and the hospital or care home in which he is held.⁷³

Whether a person is deprived of his liberty is a matter of fact. While there will not be any dispute that a patient held under section 3 MHA is deprived of his liberty, the issue is controversial for the purposes of the DOLS. According to the DOLS Code of Practice, the appropriate use of restraint on a patient will fall short of a full deprivation of liberty.⁷⁴ Yet the distinction between mere restraint and a deprivation of liberty which engages Article 5(1) ECHR is difficult to draw in the abstract. The DOLS Code of Practice only provides examples of factors that may be relevant to this assessment.⁷⁵ Baker J was equally equivocal in CC v KK and Another,⁷⁶ where His Lordship said that the court must take account 'of a whole range of criteria such as the type, duration, effects and manner of implementation of the measure in question.'⁷⁷ As a result of these considerations, what will amount to a deprivation of liberty varies on a case-by-case basis. If a person actively resists or protests against his admission to hospital,⁷⁸ is subject to complete and effective control⁷⁹ or

⁷³ Paras.1(1)-(4) of Part 1 of Sch.A1 to the MCA 2005.

⁷⁴ DOLS Code of Practice, *supra* n.67, at para.2.9.

⁷⁵ *Ibid*, at para.2.5.

⁷⁶ [2012] EWHC 2136 (COP).

⁷⁷ CC v KK and Another, *per* Baker J at para.86.

⁷⁸ JE v DE and Surrey County Council [2006] EWHC 3459 (Fam); Hillingdon London Borough Council v Neary (by his Litigation Friend the Official Solicitor) and Another [2011] EWHC 1377 (COP).

⁷⁹ HL v United Kingdom.

continuing one-to-one supervision by healthcare professionals,⁸⁰ or is constantly kept on a locked ward and prohibited from leaving,⁸¹ his circumstances are likely to amount to a deprivation of liberty. By contrast, if a person lives at home in the care of a loving family,⁸² can move freely within an unsecure setting,⁸³ enjoys regular outings and attends education or training sessions,⁸⁴ or is subject to restrictions which would not exceed what would be reasonably required to protect a patient in comparable circumstances from harming himself,⁸⁵ then he is unlikely to have been deprived of his liberty.

Assuming that a person lacking capacity has been or will be deprived of his liberty in a hospital or care home, the DOLS provide a legal framework to authorise such an arrangement. If the managing authority of a hospital wishes to deprive a patient of his liberty, it must apply to its supervisory body for a 'standard authorisation'⁸⁶ in accordance with Schedule A1 to the MCA 2005.⁸⁷ A managing authority may also give itself an 'urgent authorisation'⁸⁸ in circumstances where the need to deprive the relevant person of his liberty is so urgent that there is no time to apply for a standard authorisation or to wait for

⁸⁰ A Local Authority v H [2012] EWHC 49 (COP).

⁸¹ Storck v Germany (2005) 43 EHRR 96; see also Baker J in CC v KK and Another at para.100.

⁸² Re A, Re C [2010] EWHC 978 (Fam).

⁸³ HM v Switzerland (2002) 38 EHRR 314.

⁸⁴ Surrey County Council v P [2011] EWCA Civ 190.

⁸⁵ RK (by her Litigation Friend the Official Solicitor) v BCC and Others [2011] EWCA Civ 1305; Chester West and Cheshire Council v P [2011] EWCA Civ 1257; Nielsen v Denmark (1988) 11 EHRR 175.

⁸⁶ See generally Part 4 of Sch.A1 to the MCA 2005.

⁸⁷ Para.2 of Part 1 of Sch.A1 to the MCA 2005.

⁸⁸ See generally Part 5 of Sch.A1 to the MCA 2005.

such an application to be determined.⁸⁹ In the case of a standard authorisation, the managing authority must apply to its supervisory body where the relevant person is (i) about to be or is already accommodated in a hospital or care home, (ii) likely to be a detained resident within the next twenty-eight days, and (iii) likely to meet all of the qualifying requirements set out in Part 3 of Schedule A1 to the MCA 2005.⁹⁰ There are six qualifying requirements: age,⁹¹ mental health,⁹² mental capacity,⁹³ best interests,⁹⁴ eligibility,⁹⁵ and no refusals.⁹⁶ Once the supervisory body receives an application for a standard authorisation, it must ensure that the relevant person is assessed in order to determine whether he meets all of these qualifying criteria.⁹⁷ If so, the supervisory body is under a duty to give a standard authorisation.⁹⁸

3.2.3. The Qualifying Requirements: the Interface between the DOLS and the MHA

Determining whether the relevant person meets the qualifying criteria is perhaps the most challenging aspect of the DOLS regime. If the relevant person does not meet all of the

⁸⁹ Paras.74 and 76 of Part 5 of Sch.A1 to the MCA 2005. An urgent authorisation applies for no more than seven days (para.78(2) of Part 5 of Sch.A1 to the MCA 2005) but it may be extended for a further seven days on request (paras.84 and 85 of Part 5 of Sch.A1 to the MCA 2005).

⁹⁰ Para.24(1)-(5) of Part 4 of Sch.A1 to the MCA 2005.

⁹¹ Para.12(1)(a) of Part 3 of Sch.A1 to the MCA 2005.

⁹² Para.12(1)(b) of Part 3 of Sch.A1 to the MCA 2005.

⁹³ Para.12(1)(c) of Part 3 of Sch.A1 to the MCA 2005.

⁹⁴ Para.12(1)(d) of Part 3 of Sch.A1 to the MCA 2005.

⁹⁵ Para.12(1)(e) of Part 3 of Sch.A1 to the MCA 2005.

⁹⁶ Para.12(1)(f) of Part 3 of Sch.A1 to the MCA 2005.

⁹⁷ Para.33 of Part 4 of Sch.A1 to the MCA 2005.

⁹⁸ Para.50 of Part 4 of Sch.A1 to the MCA 2005.

criteria it follows that he should either be treated voluntarily or 'sectioned' under the MHA. The qualifying criteria therefore establish the interface between the DOLS and the MHA. It is true that some of the criteria are easier to assess than others; for example, the relevant person must be least eighteen years of age to satisfy the age requirement,⁹⁹ and the 'no refusals' criterion precludes a standard authorisation where the relevant person has refused some or all of the proposed treatment in an applicable advance decision¹⁰⁰ or where his admission will conflict with a valid decision of a donee of a lasting power of attorney or a deputy appointed by the court.¹⁰¹ The mental health and mental capacity requirements are similarly straightforward: the relevant person must be suffering from a mental disorder within the meaning of section 1(2) of the MHA¹⁰² and must lack capacity to decide whether he should be accommodated in the relevant hospital or care home.¹⁰³ Things get trickier when it comes to the best interests requirement. Here, the assessor must be satisfied that it is (i) in the relevant person's best interests for him to be deprived of his liberty, (ii) necessary for the relevant person to be detained in order to prevent harm to him, and (iii) a proportionate response to the likelihood of the relevant person suffering harm and the

⁹⁹ Para.13 of Part 3 and para.34 of Part 4 of Sch.A1 to the MCA 2005.

¹⁰⁰ Para.19(1) and (2) of Part 3 and para.48 of Part 4 of Sch.A1 to the MCA 2005. On lasting powers of attorney, see MCA 2005, ss.9-14.

¹⁰¹ Para.20(1)-(3) of Part 3 and para.48 of Part 4 of Sch.A1 to the MCA 2005. On the appointment of deputies by the court, see MCA 2005, ss.15-21.

¹⁰² Importantly, the exclusion of learning disabilities from the MHA's definition of 'mental disorder' under s.1(2A) of the 1983 Act does not apply to the DOLS. See para.14(1) of Part 4 and para.35 of Part 4 of Sch.A1 to the MCA 2005.

¹⁰³ Para.15 of Part 3 and para.37 of Part 4 of Sch.A1 to the MCA 2005. According to ss.2(1) and 3(1) of the MCA 2005, a person lacks capacity where he is unable to make a decision for himself because of an impairment of, or a disturbance in the functioning of, his mind or brain, which leaves him unable to (a) understand the information relevant to a decision, (b) retain that information, (c) use or weigh that information as part of the decision-making process, or (d) communicate his decision.

seriousness of that harm.¹⁰⁴ The wording here bears a striking similarity to the MHA's risk formula, suggesting that there must also be some element of risk under the DOLS framework before the managing authority can receive a standard authorisation. Yet there are two crucial differences which reveal the boundary between the Safeguards and the MHA. First, Schedule A1 to the MCA 2005 refers only to detention which is necessary to prevent harm *to the relevant person*. This is clearly a narrower and less urgent conception of risk than that which applies under the MHA. We can infer from paragraph 16(4) of Schedule A1 that the Safeguards are designed to apply to mentally disordered patients whose lack of capacity puts them at risk *of neglecting their own welfare*. This contrasts with the Part II of the MHA, whose provisions anticipate that the compulsory powers should be deployed to reduce or extinguish much graver risks to the patient and the community, such as deliberate self-harm or violence. Secondly, the DOLS provisions specifically incorporate the concept of risk into the assessment of the relevant person's best interests. The MCA 2005 provides that where a person lacks capacity the decision-maker should consider, *inter alia*, the person's past and present wishes and feelings, his beliefs and values, and any other factors that would likely influence his decision in order to give effect to his best interests.¹⁰⁵ The decision-maker should therefore aim to take a decision that is broadly commensurate with what the patient might decide in the circumstances if he had had the capacity to do so.¹⁰⁶

¹⁰⁴ Para.16(2)-(5) of Part 3 and paras.38 and 39 of Part 4 of Sch.A1 to the MCA 2005. See also, MCA 2005, s.4.

¹⁰⁵ MCA 2005, s.4(6)(a)-(c).

¹⁰⁶ MCA 2005, s.4 does not define what 'best interests' are. Instead, according to s.4(2), decision-makers must consider all the 'relevant circumstances'. Case law predating the 2005 Act suggests that the court will evaluate the patient's best interests broadly; see, e.g., Re MB (Medical Treatment) [1997] 2 FLR 426, in which the Court of Appeal said that considerations of patients' best interests should not be limited only to clinical matters; Re A (Male Sterilisation) [2000] 1 FLR 549, in which Butler-Sloss LJ said that 'best interests' include 'medical, emotional and all other welfare issues'; and

Implicit in the juxtaposition of the concept of risk and best interests in the qualifying criteria is a patient-centred construction which assumes that the patient would want his clinical team to address the risks of harm to his welfare. The Safeguards thus draw an inextricable link between reducing risk to the relevant person and enhancing his best interests. No such link exists in the MHA, whose utilitarian approach contrasts markedly with the DOLS' framework – whether a patient's compulsory admission is in his best interests is irrelevant to the MHA. Through these two differences we can see that the DOLS framework has demarcated a clear niche for the MHA's compulsory powers, which apply (i) where the patient poses graver risks to himself or others and (ii) according to a paternalistic imperative.

The DOLS' eligibility requirement further reinforces the distinction between the Safeguards and the MHA. According to paragraph 17(1) of Part 3 of Schedule A1 to the MCA 2005, 'the relevant person meets the eligibility requirement *unless* he is ineligible to be deprived of his liberty by this Act.'¹⁰⁷ In order to establish whether or not the relevant person is so ineligible, the assessor must consult Schedule 1A to the MCA 2005.¹⁰⁸ The simplest way in which the relevant person will be rendered ineligible to detention is where he is (a) subject to a hospital treatment regime, and (b) detained in a hospital under that regime;¹⁰⁹ in other words, where he is subject to the MHA's compulsory powers.

Trust A v H [2006] 9 CCLR 474, in which 'best interests' was taken to refer to a 'broad spectrum of medical, social, emotional and welfare issues'.

¹⁰⁷ Emphasis added.

¹⁰⁸ Para.17(2) of Part 3 of Schedule A1 to the MCA 2005.

¹⁰⁹ See 'Case A' in the table under para.2 of Part 1 of Schedule 1A to the MCA 2005. A 'hospital treatment regime' is defined as a 'hospital treatment obligation under the relevant enactment', which applies to, *inter alia*, the compulsory powers under ss.2, 3 and 4 MHA 1983 (see para.8 of Part 2 of Schedule 1A to the MCA 2005).

Consequently, there is no scope for overlap between DOLS and the MHA; the latter will *always* have primacy over the former in these circumstances. The question of the relevant person's eligibility becomes more complex where he is (a) within the scope of the MHA, but (b) not subject to any of its mental health regimes.¹¹⁰ The relevant person will be 'within the scope' of the MHA if (a) an application could be made in respect of him under sections 2 or 3 of the 1983 Act, and (b) he could be detained in hospital in pursuance of such an application were one made.¹¹¹ In these circumstances, the relevant person will be ineligible to be deprived of his liberty under the DOLS framework where (i) the standard authorisation would authorise the relevant person to be a mental health patient, (ii) the relevant person objects either to being a mental health patient or to being given some or all of the mental health treatment, and (iii) a donee or deputy has not made a valid decision to consent to each matter to which the relevant person objects.¹¹² This means that a patient who is within the scope of the MHA but does not object to his admission to hospital or to an aspect of his treatment therein can be the subject of a standard authorisation.

The eligibility requirement offers the clearest distinction between the DOLS and the MHA. A mentally disordered person lacking capacity may satisfy the MHA's risk formula and be subject to *either* a standard authorisation or compulsory admission under sections 2 or 3. In these circumstances, it may be the case that choosing between the DOLS and admission under the MHA is a matter of preference for the decision-maker.¹¹³ However, once that

¹¹⁰ See 'Case E' in the table under para.2 of Part 1 of Schedule 1A to the MCA 2005.

¹¹¹ Para.12(1)(a) and (b) of Part 2 of Schedule 1A to the MCA 2005.

¹¹² Para.5(2)-(5) of Part 2 of Schedule 1A to the MCA 2005.

¹¹³ P. Bartlett, 'Civil Commitment' in L. Gostin *et al* (eds.) *Principles of Mental Health Law and Policy*, Oxford: OUP, 2010, at p471.

patient objects, or manifests his objection,¹¹⁴ to his admission to hospital or to an aspect of his treatment he puts himself outside the ambit of the DOLS. In those circumstances, the risks become too great for that patient to remain beyond the scope of a compulsory legal framework. In this way, the MHA occupies a superior position to the DOLS on the hierarchy of care and treatment mechanisms for mentally disordered persons. It must be remembered that the interface between the two regimes only becomes relevant in these Bournewood-style situations. In all other circumstances, once a patient meets the criteria for admission under the MHA he can be 'sectioned' *irrespective* of his capacity to consent to his detention in hospital; he does not have to escalate through the DOLS regime first. In J v The Foundation Trust,¹¹⁵ Charles J affirmed that the MHA has primacy over the safeguards. Here, the claimant argued that he was 'ineligible to be deprived of liberty' within the meaning of Schedule 1A and applied for a court order under section 21A of the MCA 2005 terminating the standard authorisation. The Court of Protection refused the application on the basis that the claimant required treatment for diabetes, a physical disorder, as opposed to treatment for a mental illness. For that reason, he satisfied the eligibility requirement for a standard authorisation.¹¹⁶ Charles J pointed out that decision-makers 'cannot pick and choose between the two statutory regimes as they think fit having regard to general considerations that they consider render one regime preferable to the other.'¹¹⁷ His

¹¹⁴ Para.6 of Part 2 of Schedule 1A to the MCA 2005.

¹¹⁵ [2009] EWHC 2972 (Fam).

¹¹⁶ C.f., DN v Northumberland Tyne and Wear NHS Foundation Trust [2011] UKUT 327 (AAC), in which Jacobs J said, at para.20, that it is not possible to say which of the MCA 2005 and MHA 1983 has priority over the other 'without reference to the circumstances of the particular case'. In this case, the relevant person did not fall within the scope of ss.2 or 3 MHA because he did not require admission for assessment and there was no appropriate treatment available for him. There was therefore no reason why the relevant person could not be detained under the DOLS.

¹¹⁷ *Ibid*, per Charles J at para.45.

Lordship reasoned that the original purpose behind the introduction of the DOLS was not to provide 'alternative regimes' but rather to 'leave the existing regime under the 1983 Act in place with primacy and to fill a gap left by it and the common law.'¹¹⁸ Consequently, while the DOLS regime allows a mentally disordered and incapacitated patient to be detained in hospital in his best interests, the MHA still trumps it where that patient poses the requisite degree of risk. The DOLS framework therefore implicitly reinforces the role of risk as the key component of the MHA framework.

3.3. The Panoply of Risk

It is clear that patients subject to the civil commitment powers occupy a unique position: unlike voluntary or informal mental health patients interacting with ordinary health services, 'sectioned' patients are typically detained in secure settings, placed under the control of their clinical team, and given medical treatment, often irrespective of their capacity to consent.¹¹⁹ This characteristic of civil commitment amounts to what the US Supreme Court has described as 'a massive curtailment of liberty'.¹²⁰ As Lady Hale points out in Savage v South Essex Partnership NHS Foundation Trust,¹²¹ detained patients cannot choose the hospitals in which they are to be placed, the doctors who are to treat them, or the medical treatment which is to be administered for their disorders.¹²² Where a patient is

¹¹⁸ *Ibid*, at para.60.

¹¹⁹ The distinction between formal and informal patients has not always been clear cut. See, e.g., A. Rogers, 'Coercion and "Voluntary" Admission: An Examination of Psychiatric Patient Views' (1993) 11 *Behavioural Sciences and the Law* 259; the Bournewood case.

¹²⁰ Humphrey v Cady 405 US 504 (1972).

¹²¹ [2008] UKHL 74.

¹²² *Ibid*, at para.94.

placed is a matter for the hospital managers; how he is to be treated is an issue for his clinical team.¹²³ Once a patient is deemed to pose a risk to himself or others, the MHA suspends his rights to autonomy and self-determination, thereby transforming his interaction with his clinical team to one characterised by control and coercion.

It seems curious, then, that the MHA neither defines 'risk' nor delimits the factors that are to have probative value for decision-makers trying to establish whether a patient should be admitted to hospital in the interests of his health or safety or for the protection of others. In fact, prior to the 2007 Act, the word 'risk' did not feature in the MHA at all. Since the 2007 Act came into force, the word now appears on a handful of occasions, typically in conjunction with the risk formula.¹²⁴ The amended MHA does not offer any guidance on how decision-makers should interpret 'risk', despite provision being made for other terms whose definition is fundamental to the compulsory powers, e.g., 'medical treatment'.¹²⁵ There is some guidance as to what evidence might be *indicative* of risk, although this relates only to the new SCT regime and is in no way exhaustive.¹²⁶ This is the closest the MHA gets to itemising the factors that should have a bearing on decision-makers' assessments. For the

¹²³ See also Coombs v Dorset NHS Primary Care Trust [2012] EWHC 521 (QB), where Supperstone J accepted, at para.58, that the position of a detained patient 'cannot automatically be equated with that of an ordinary patient'. This was affirmed by the Court of Appeal in Coombs v Dorset NHS Primary Care Trust [2013] EWCA Civ 471.

¹²⁴ MHA 1983, ss.17A(6); 17B(2)(b); 17E(1)(b); 20A(7); 41(1); 43(1)(b); and 72(1A). These provisions relate to CTOs, restriction orders, and the discharge power of the MHRT.

¹²⁵ MHA 1983, s.145.

¹²⁶ One of the pre-requisites for SCT states that it is necessary that the responsible clinician should be able to exercise the power to recall the patient to hospital under MHA, s.17E(1). In determining whether this condition is met, s.17A(6) states that the responsible clinician shall consider 'having regard to the patient's history of mental disorder and any other relevant factors, what risk there would be of a deterioration of the patient's condition if he were not detained in a hospital (as a result, for example, of his refusing or neglecting to receive the medical treatment he requires for his mental disorder)'.

most part, the MHA sheds no light on what 'risk' means, what the word adds to the 'risk formula' when read in conjunction with it, or what evidence might support the conclusion that a patient poses a risk to his health or safety or to others. This absence of statutory prescription is particularly surprising in light of the prominence given to the risk agenda by policy-makers before the 2007 Act was passed. We can only really be sure of what risk is *not*: according to Lady Hale, the law does not require the patient to pose a *danger* to himself or others as a prerequisite for admission. 'Danger' appears in the Act as a distinct criterion for the quite different purpose of preventing the patient's nearest relative from discharging him from hospital.¹²⁷ The fact that the MHA's risk formula is worded differently implies that the criteria for compulsory admission do not require that the patient be dangerous.¹²⁸ Lady Hale believes therefore that risk is a lower standard, which would reflect the fact that the criteria for initial admission to hospital 'were meant to be broader than those for keeping him there against the wishes of his family'.¹²⁹ Her Ladyship's view appears to be supported by authority: in R (on the application of O) v West London Mental Health

¹²⁷ B. Hale, *Mental Health Law*, 5th ed., London: Sweet and Maxwell, 2010, at p58. See MHA, s.25(1), which allows a responsible clinician to block an attempt by the nearest relative to discharge the patient if, in the clinician's opinion, the patient, if discharged, 'would be likely to act in a manner dangerous to other persons or to himself'.

¹²⁸ See, e.g., D. Pilgrim and A. Rogers, 'Two Notions of Risk in Mental Health Debates' in T. Heller *et al* (eds.) *Mental Health Matters: A Reader*, Basingstoke: Palgrave MacMillan, 1996, who contend, at p183, that the notion of 'health or safety' in the MHA is much wider than 'danger', and thereby 'legitimises [the deployment of the] wide-ranging powers of professionals'; see also H. Prins, 'Risk Assessment and Management in Criminal Justice and Psychiatry' (1996) 7(1) *Journal of Forensic Psychiatry* 42, who distinguishes, at p44, 'risk', which is the likelihood of an event occurring, and 'danger', which is the degree of damage that may occur should the event happen; and c.f. V.A. Hiday and S.J. Markell, 'Components of Dangerousness: Legal Standards in Civil Commitment' (1980) 3(4) *International Journal of Law and Psychiatry* 405, who would argue that dangerousness as a standard for civil commitment is no more certain than the concept of risk.

¹²⁹ *Ibid.*

NHS Trust,¹³⁰ Collins J said that the term ‘dangerous’ in section 25(1) requires that decision-makers specifically address an ‘extra factor’ when deciding whether to bar discharge by the nearest relative.¹³¹ However, what that standard might be and how it differs from risk is an issue for decision-makers.

The Code of Practice which accompanies the MHA sheds little further light on the issue.¹³² It too does not define ‘risk’ and thereby offers no further guidance to practitioners. Instead, the Code sets out a non-exhaustive list of factors for decision-makers to consider. Where a patient’s health or safety are concerned, practitioners should consider evidence suggesting either that he is at risk of suicide, self-harm, self-neglect (or being unable to look after his own health or safety), or of jeopardising his health or safety accidentally, recklessly or unintentionally; or that his mental disorder is otherwise putting his health or safety at risk.¹³³ Practitioners might also consider any evidence suggesting that the patient’s mental disorder will deteriorate without treatment, the reliability of that evidence, the views of the patient, his experience in managing his condition, the potential benefits of treatment, and whether other methods of managing risk are available.¹³⁴ In relation to harm to others,

¹³⁰ [2005] EWHC 604 (Admin).

¹³¹ *Ibid*, at para.14. See also R (on the application of Huzzey) v Riverside Mental Health Trust (1998) 43 BMLR 167; R v Secretary of State for the Home Department, ex parte Benson 9th November 1988 (unreported), in which Lloyd LJ impliedly distinguishes ‘dangerousness’ and ‘risk’ for the purposes of Part III of the Criminal Justice Act 1967 by saying that a prisoner’s dangerousness is ‘difficult to forecast’ and this is ‘not made easier by substituting “risk” as a synonym’. C.f. R v Secretary of State for the Home Department [1998] 1 WLR 503, CA.

¹³² MHA, s.118(1) imposes a duty on the Secretary of State to prepare a Code of Practice to guide registered medical practitioners. While it is not legally binding, there must be cogent reasons to justify a departure from the Code’s guidance (R (on the application of Munjaz) v Mersey Care NHS Trust [2006] 2 AC 148, HL).

¹³³ Department of Health, *Code of Practice: Mental Health Act 1983*, Norwich: TSO, 2008, at para.4.6.

¹³⁴ *Ibid*.

decision-makers should consider the nature of the risk (which encompasses both physical and psychological harm), the likelihood that it will occur and the severity of any potential harm.¹³⁵ They should also take into account the challenges inherent in differentiating the risks of harm to the patient from those to others.¹³⁶ It is clear that the Code establishes very broad parameters, allowing decision-makers to respond to any physical and psychological hazards that a person with mental disorder may pose to himself or others. This means that there are few limits on what can serve as evidence of risk, allowing decision-makers to deploy the compulsory powers in a wide range of circumstances. Importantly, the Code does not suggest that the two recommending doctors have to agree on the nature of the risk that justifies detention under either section 2 or 3, meaning that each decision-maker might come to the same conclusion but by different means.¹³⁷

Far from clarifying the meaning of ‘risk’, the Code raises even more questions. First, it is not exhaustive; the language it uses suggests that there may be other relevant factors beyond those to which it refers explicitly. Its tone is advisory as opposed to imperative. It uses open-ended phrases like ‘Factors to be considered...*include...*’ and terms like ‘such as’ and ‘any other methods’, which do not preclude decision-makers from going beyond the text of the guidance. The Code thus does not presume any authority to second-guess clinicians. In effect, it offers a basis on which decision-makers can commence their evaluations, but it does not delimit exhaustively the factors that may be relevant to a patient’s profile. Secondly, the Code fosters what might be described as a ‘risk is risk’

¹³⁵ *Ibid*, at para.4.7.

¹³⁶ *Ibid*.

¹³⁷ R. Jones, *Mental Health Act Manual*, 14th ed., London: Sweet and Maxwell, 2011, at para.1-040.

paradox.¹³⁸ According to the Code, one of the factors for practitioners to consider when evaluating a patient's health or safety is any evidence that suggests that the patient is *at risk* of suicide. This produces an absurdity in that the patient's *risk* of suicide serves as evidence that he poses a *risk* to his health or safety. Given that the MHA does not feature an objective interpretation of 'risk', this paradox in no way clarifies what the word means or the factors that might be relevant to it. At best, it constitutes a tautological definition, or 'diallelon'.¹³⁹ It creates a circular concept in which imputations of risk become self-evident truths; by saying that a patient poses a risk because there is a risk that he may commit suicide, decision-makers simply defer the definition problem. The Code legitimises this phenomenon by allowing decision-makers to justify their assessments of risk by building 'chains' of smaller risks which underpin their overall conclusions. In effect, each link in the chain supports the assumptions of the next and ultimately they culminate in a conclusion that is, notionally at least, objectively justifiable. The problem is that by relying on risk in each link of the chain, it does not necessarily follow that the evidence supports the practitioner's overall conclusion. Indeed, the last link in the chain may not be a logical corollary of the first. The flow charts below illustrate this phenomenon:

¹³⁸ See also, N. Glover-Thomas, 'The Age of Risk: Risk Perception and Determination Following the Mental Health Act 2007' (2011) 19(4) *Medical Law Review* 581.

¹³⁹ I. Hacking, *The Taming of Chance*, Cambridge: Cambridge University Press, 1990, at p213.

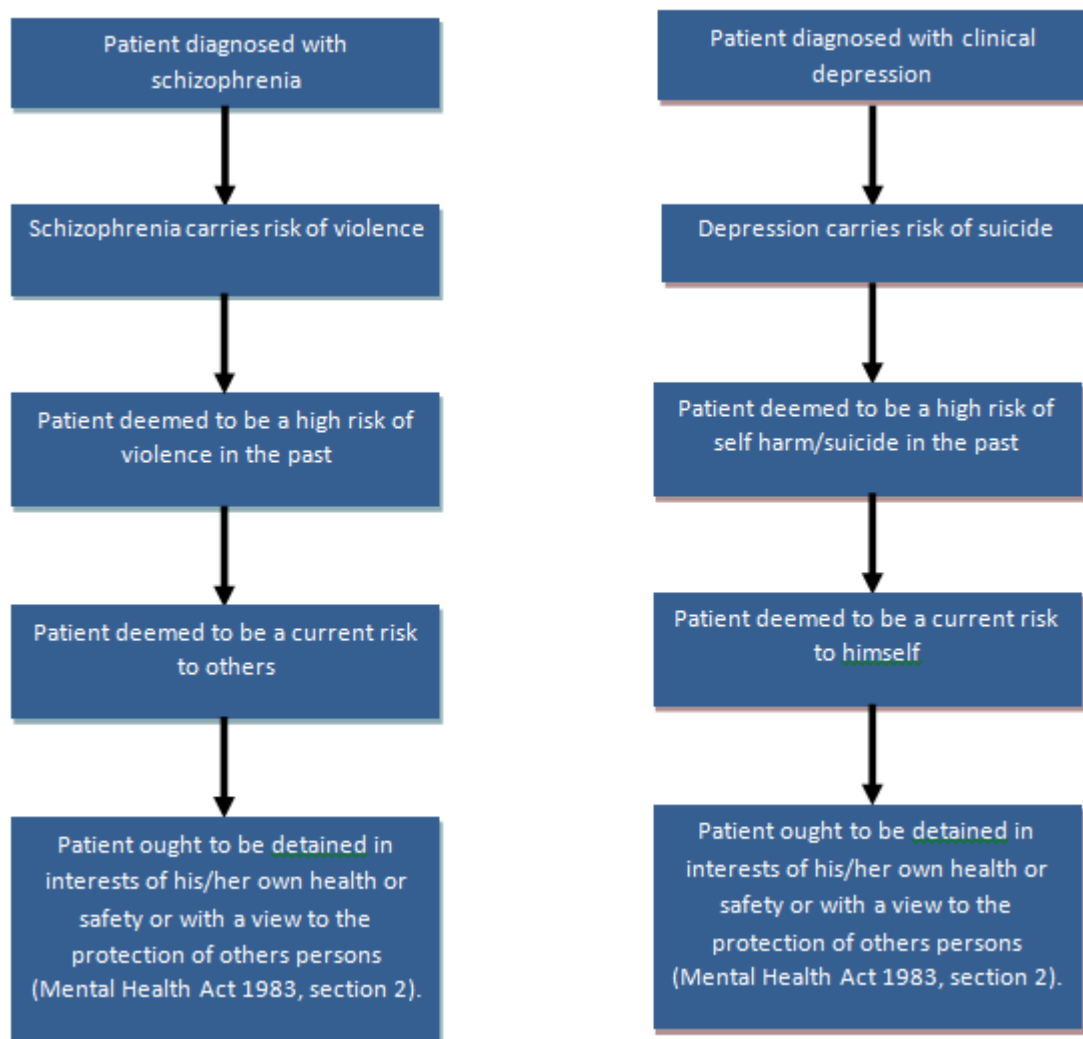


Figure 3.2. Flow charts illustrating the mechanics of the ‘risk is risk’ paradox engendered by the MHA and its accompanying Code of Practice.

By giving decision-makers leeway to interpret certain factors as evidence of risk, the Code’s guidance actually makes the threshold for intervention under the MHA even less certain.

Other extra-legal guidance further adds to this uncertainty. Guidance from the Department of Health published in 2007 explicitly recognised that the assessment of risk is a wholly subjective exercise whose conclusions can be influenced by practitioners’ personal values, attitude towards risk and workload.¹⁴⁰ This suggests that risk-based decision-making

¹⁴⁰ Department of Health, *Best Practice in Managing Risk: Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services*, 2007, at p29.

is not an objectively-justifiable exercise. Further, Langan and Lindow argue that it is good practice for mental health professionals who are evaluating the interests of a patient's health or safety to conduct an 'holistic assessment' which considers *all* of the factors affecting his life as opposed to focusing too narrowly on the risk of suicide, for example.¹⁴¹ In their view, practitioners should evaluate the impact of broader factors like unemployment, poverty, stigma, discrimination or racism. For that reason, the patient's social functioning and current circumstances can be brought within the ambit of mental health practitioners' competence.¹⁴² While this may be an expedient way to assess risk, it also has the effect of extending the reach of the MHA's compulsory powers.

The Department of Health's guidance has endorsed this broad-based approach. It said that the factors relevant to risk can be classified as 'static', 'dynamic', 'stable' or 'chronic', or 'acute'.¹⁴³ Mersey Care NHS Trust, a specialist mental health service, publishes its own guidance for practitioners which employs a different system of classification to distinguish 'predisposing factors' (e.g., personality disorder, a history of abuse) from 'triggers' (e.g., intoxication, paranoia).¹⁴⁴ Although these classifications may help decision-makers to categorise factors, they have arisen independently of the MHA. This is perhaps unsurprising given that the Act is silent about how decision-makers should interpret risk. It is clear that

¹⁴¹ J. Langan and V. Lindow, *Living with Risk: Mental Health Service User Involvement in Risk Assessment and Management*, The Policy Press, 2004, at p51.

¹⁴² *Ibid*, at p25.

¹⁴³ *Best Practice in Managing Risk*, *supra* n.140, at pp13-14. 'Static' factors are those unchanging issues which are part of the patient's history, e.g., if he was a victim of abuse as a child; 'dynamic' factors encompass issues that change over time, e.g., the misuse of alcohol or drugs; 'stable' factors take a long time to change; and 'acute' factors change rapidly. Available at: <http://www.nacro.org.uk/data/resources/nacro-2007070300.pdf>. Accessed: 1st October 2009.

¹⁴⁴ Mersey Care NHS Trust, *Organisation Portfolio: Clinical Risk Assessment Tools*, March 2009, at p7.

an assessment of a patient's risks might draw upon an infinite number of factors relating to, *inter alia*, his clinical diagnosis, characteristics, circumstances, habits and relationships. It is also the case that the probative value of such factors is entirely a matter for decision-makers' subjective interpretation. Extra-legal guidance is undoubtedly intended to fill the vacuum. What is troubling is that it is difficult to know how such guidance affects the functioning of the compulsory powers. In procedural terms, it is not clear whether the guidance is intended to be determinative, how nationally- and locally-produced documents should relate to each other and what decision-makers should do in the event of a clash. There is no instruction about how decision-makers should weigh the evidence; they can presumably attach such weight to risk indicators as they see fit, meaning that factors never truly have an objective value. In addition, decision-makers are not instructed, for example, that *n* static or predisposing factors co-present with *n* acute factors or triggers will indicate detention every time. Instead, they enjoy a free hand to identify and attribute value to any risk factors that they consider material. To make matters more confusing, persons with a particular mental disorder displaying the same or similar risk factors may behave differently. Factors indicating that a patient is at a high risk of suicide do not necessarily mean that without compulsory intervention he/she is certain to kill him/herself. Similarly, a patient suffering from depression *not* exhibiting any risk factors may still attempt to kill him/herself.¹⁴⁵ The factors that may (or may not) be relevant to risk in mental health

¹⁴⁵ See, e.g., J. Langan, 'Assessing Risk in Mental Health' in P. Parsloe (ed.) *Risk Assessment in Social Care and Social Work*, London: Jessica Kingsley Publishers, 1999, at p171.

decision-making are diverse and their value is variable. Assessing risk appears to be such an inexact science that it is difficult to resist the conclusion that anything goes.¹⁴⁶

This uncertainty is more than merely theoretical; it has genuine practical consequences. In the absence of a fixed definition of risk, mental health professionals are left free to devise their own interpretations of it. The result may be widespread confusion, thereby undermining psychiatrists' claims to possess expertise when assessing risk. In a study comparing psychiatrists' assessments of dangerousness with those of teachers, Quinsey and Ambtman found that there was no evidence that clinicians were any more expert than laypeople.¹⁴⁷ They argued that a group of professionals can only demonstrate expertise on a particular topic where they (a) agree amongst themselves, (b) are accurate in their judgements, (c) make different judgements from laypeople, and (d) make use of specialised procedures in reaching their decisions.¹⁴⁸ Their study found that psychiatrists failed on each point and were therefore no more competent to predict dangerousness among mentally disordered patients than schoolteachers. In a more recent study of the responses to risk among nurses and social workers caring for vulnerable people in the community, Alaszewski and Alaszewski found that 'risk' was a 'taken-for-granted word' which most of the

¹⁴⁶ The courts make allowances for this. See, e.g., *Johnson v United Kingdom* (1997) 27 EHRR 296: 'It must also be observed that in the field of mental illness the assessment as to whether the disappearance of the symptoms of the illness is confirmation of complete recovery is not an exact science. Whether or not recovery from an episode of mental illness which justified a patient's confinement is complete and definitive or merely apparent cannot in all cases be measured with absolute certainty'; *R (on the application of B) v Ashworth Hospital Authority* [2005] UKHL 20, *per* Baroness Hale at paras.30-1: 'Psychiatry is not an exact science... Once the state has taken away a person's liberty and detained him in hospital with a view to medical treatment, the state should be able to provide him with the treatment which he needs.'

¹⁴⁷ V.L. Quinsey and R. Ambtman, 'Variables Affecting Psychiatrists' and Teachers' Assessments of the Dangerousness of Mentally Ill Offenders' (1979) 47(2) *Journal of Consulting and Clinical Psychology* 353, at p361.

¹⁴⁸ *Ibid*, at p354.

participants struggled to define.¹⁴⁹ While the respondents acknowledged that the assessment of risk is an important part of mental health practice, they had not given any thought to what it actually meant.¹⁵⁰ For the most part, they instinctively regarded the concept in 'everyday' terms.¹⁵¹ Only when they were prompted by the research team did the respondents come to recognise that risk is in fact a complex and multi-faceted concept which can also have a 'positive' dimension.¹⁵² We will return to explore this further in chapter four, but it is worth pointing out that this lack of consistency among decision-makers may be related to the failure of the MHA to clarify the meaning of the concept.

The lack of consistency is also almost certainly the reason why there is such wide variation in the methods used to assess and quantify risk across different NHS Trusts. Not only are decision-makers confused about the meaning of 'risk', it seems that there is no agreement about how it should be assessed. According to the Department of Health's guidance from 2007, decision-makers may opt to use actuarial methods, unstructured clinical approaches, or a blending of the two.¹⁵³ This advice suggests that there is unlikely to

¹⁴⁹ H. Alaszewski and A. Alaszewski, 'Professionals and Practice: Decision-making and Risk' in A. Alaszewski *et al* (eds.) *Risk, Health and Welfare: Policies, Strategies and Practice*, Buckingham: Open University Press, 1998, at pp107-8.

¹⁵⁰ *Ibid*, at p114.

¹⁵¹ *Ibid*. See also p111.

¹⁵² *Ibid*.

¹⁵³ Department of Health, *Best Practice in Managing Risk*, *supra* n.140, at pp18, 20. On blending clinical and actuarial approaches, see M. Dolan and M. Doyle, 'Violence Risk Prediction: Clinical and Actuarial Measures and the Role of the Psychopathy Checklist' (2000) 177(4) *British Journal of Psychiatry* 303, who talk, at p304, about the benefits of 'structured clinical judgement'; and M. Doyle and M. Dolan, 'Violence Risk Assessment: Combining Actuarial and Clinical Information to Structure Clinical Judgements for the Formulation and Management of Risk' (2002) 9(6) *Journal of Psychiatric and Mental Health Nursing* 649, who refer, at p652, to the 'third generation approach' in which the emphasis is on 'evidence-based guidelines...that promote...consistency yet are flexible enough to account for case-specific influences'.

be much consistency in processes across mental health services. The evidence supports this. Higgins *et al* found that while 67 *per cent* of the English NHS Trusts they surveyed had individual, standardised protocols for the assessment of patients with mental disorder, practice was still highly variable in the aggregate.¹⁵⁴ Similarly, Hawley *et al* discovered that there is no standardised risk assessment pro-forma governing decision-making in the NHS. They analysed fifty-three risk assessment tools used by different Trusts and found that they varied in length, consisting of anywhere between one and six pages and five and 148 items.¹⁵⁵ A vast majority of the sample (84.2 *per cent*) relied on forced-choice dichotomies (i.e., decision-makers had to give either 'yes' or 'no' answers), whereas only 7.5 *per cent* of the pro-formas permitted free-text responses from practitioners. Interestingly, fully forty-two *per cent* of the sample recommended that decision-makers complete *further* risk assessment forms once the principal pro-forma was finished, suggesting that procedures at some Trusts were rather protracted. Even more astonishing is the fact that most of the pro-formas Hawley *et al* analysed did not require the completer to make any predictive statements about the patient's risks to himself or others,¹⁵⁶ which is the intended purpose of a risk assessment. It is clear, then, that there is no agreement about the nature and purpose of risk assessment between decision-makers.

This raises a broader issue. Questions about psychiatrists' ability to reach legally *reliable* and *valid* conclusions about mentally disordered patients' levels of dangerousness are not

¹⁵⁴ N. Higgins *et al*, 'Assessing Violence Risk in General Adult Psychiatry' (2005) 29 *Psychiatric Bulletin* 131.

¹⁵⁵ C.J. Hawley *et al*, 'Structure and Content of Risk Assessment Proformas in Mental Healthcare' (2006) 15(4) *Journal of Mental Health* 437.

¹⁵⁶ *Ibid*, at p446.

new.¹⁵⁷ In chapter one, we saw that the development of actuarial risk assessment tools offered an occasion to transform the decision-making process by substituting clinical judgements that were presumed to be unreliable with ostensibly more robust statistical approaches. It is still the case that the predictive accuracy of clinicians' unstructured decision-making is no better than chance.¹⁵⁸ Yet, it seems that attempts to develop robust risk assessment tools for use by mental health services have been largely unsuccessful.¹⁵⁹ In other words, even where standard risk assessment tools exist, their utility remains doubtful. According to Mersey Care NHS Trust's Organisation Portfolio, the Trust endorses a wide range of actuarial risk assessment tools as well as unstructured clinical interviews.¹⁶⁰ The choice of tool is a matter for the decision-maker. Depending on the context, practitioners may use the Care Programme Approach Risk Screen, Clinical Outcomes in Routine Evaluation (CORE),¹⁶¹ the Intermediate and Joint Risk Assessment and Management Plan (learning disabilities only), Short-term Assessment of Risk and Treatability (START),¹⁶² or TILT High Risk Patient Assessment (high secure services only) to assess 'multiple risks', i.e., concurrent violence, sexual harm, self-harm/suicide and self-neglect. When assessing risk to

¹⁵⁷ See, e.g., B.J. Ennis and T.R. Litwack, 'Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom' (1974) 62 *California Law Review* 693, at p695.

¹⁵⁸ J.W. Swanson, 'Preventing the Unpredicted: Managing Violence Risk in Mental Health Care' (2008) 59(2) *Psychiatric Services* 191, at p191. However, Swanson makes the point that there is an important distinction between *prediction* and *prevention* in this context. While a doctor cannot *predict* which of his patients will develop cancer with any degree of accuracy, he can take steps to *prevent* this by identifying a patient's risk factors and responding to them accordingly.

¹⁵⁹ J. Langan, 'Challenging Assumptions about Risk Factors and the Role of Screening for Violence Risk in the Field of Mental Health' (2010) 12(2) *Health, Risk and Society* 85, at p97.

¹⁶⁰ Mersey Care NHS Trust *Organisation Portfolio*, *supra* n.144, at pp15-33.

¹⁶¹ Available at <http://www.coreims.co.uk/index.php>. Accessed: 4th July 2011.

¹⁶² Available at http://www.bcmhas.ca/Research/Research_START.htm. Accessed: 4th July 2011.

others specifically, decision-makers may use the Brøset Violence Checklist,¹⁶³ the HCR-20 Violence Risk Assessment Guide,¹⁶⁴ the Risk for Sexual Violence Protocol,¹⁶⁵ the Sexual Violence Risk-20,¹⁶⁶ the Spousal Assault Risk Assessment Guide,¹⁶⁷ Stalking Assessment and Management (SAM),¹⁶⁸ or the Structured Assessment of Violence Risk in Youth (SAVRY),¹⁶⁹ again depending on the context. They may use the Beck Hopelessness Scale (BHS),¹⁷⁰ locally-devised Suicide Risk Assessment,¹⁷¹ or Skills-based, Training on Risk Management (STORM)¹⁷² when assessing the risk of self-harm and/or suicide. Where there are several tools which purport to assess risk, the Trust's guidance does not express a preference for one over the others. Consequently, there appears to be a lot of duplication among the assessment tools; four or five of them purport to do the same job.¹⁷³ In addition, decision-

¹⁶³ R. Almvik, *et al*, 'The Broset Violence Checklist: Sensitivity, Specificity and Interrater Reliability' (2000) 15 *Journal of Interpersonal Violence* 1284-1296.

¹⁶⁴ C.D. Webster, *et al*, *HCR-20: Assessing Risk for Violence*, Mental Health, Law and Policy Institute, Simon Fraser University, 1997.

¹⁶⁵ S.D. Hart, *et al*, *Risk for Sexual Violence Protocol (RSVP): Structured Professional Guidelines for Assessing Risk of Sexual Violence*, Mental Health, Law and Policy Institute, Simon Fraser University, 2003.

¹⁶⁶ D.P. Boer, *et al*, *Manual for the Sexual Violence Risk-20: Professional Guidelines for Assessing Risk of Sexual Violence*, The Mental Health, Law and Policy Institute, Simon Fraser University, 1997.

¹⁶⁷ See, *e.g.*, P.R. Kropp, *et al*, 'The Spousal Assault Risk Assessment (SARA) Guide: Reliability and Validity in Adult Male Offenders', (2000) 24(1) *Law and Human Behaviour* 101-118.

¹⁶⁸ See, *e.g.*, P.R. Kropp, *et al*, 'Risk Assessment of Stalkers: Some Problems and Possible Solutions' (2002) 29(5) *Criminal Justice and Behaviour* 590-616

¹⁶⁹ See, *e.g.*, R. Borum, 'Assessing Violence Risk Among Youth' (2000) 56(10) *Journal of Clinical Psychology* 1263-1288.

¹⁷⁰ A.T. Beck, *et al*, 'Hopelessness and Eventual Suicide: A 10-year Study of Patients Hospitalised with Suicide Ideation' (1985) 412 *American Journal of Psychiatry* 559-563.

¹⁷¹ Mersey Care NHS Trust *Organisation Portfolio*, *supra* n.144, at p32.

¹⁷² Available at <http://www.stormskillstraining.co.uk/>. Accessed 4th July 2011.

¹⁷³ Mersey Care NHS Trust *Organisation Portfolio*, *supra* n.144, at p14.

makers can continue to rely on straightforward clinical interviews – conducted in accordance with their training and expertise – to assess the same risks. In Langan’s view, the proliferation of risk assessment techniques stems from the ‘multi-factorial nature’ of patients’ risks and low base rates for violence among people with mental disorders.¹⁷⁴ Whatever the reason, the best available tool has a sensitivity rating of seventy-three *per cent* and a specificity rating of only sixty-three *per cent*, which is ‘substantially below what would be considered acceptable in [general] medicine for a screening instrument’.¹⁷⁵ Recent scholarship has criticised actuarial risk assessment tools for their tendency to prioritise the efficient allocation of resources over individuals in need of care.¹⁷⁶ More importantly, while their accuracy might have improved, actuarial methods still require the detention of up to six people a year to prevent a single violent act.¹⁷⁷ This means that statistical decision-making can only ever be truly effective where there is huge collateral of false-positives. As Hart *et al* argued in 2007, ‘it is simply impossible to make rational, reasonable and legally defensible decisions based on the results of statistical models...’¹⁷⁸

¹⁷⁴ *Ibid.*

¹⁷⁵ Swanson, *supra* n.158, at p192; see also W. Gardner *et al*, ‘A Comparison of Actuarial Methods for Identifying Repetitively Violent Patients with Mental Illnesses’ (1996) 20 *Law and Human Behaviour* 35.

¹⁷⁶ E. Silver and L.L. Miller, ‘A Cautionary Note on the Use of Actuarial Risk Assessment Tools for Social Control’ (2002) 48(1) *Crime and Delinquency* 138, at p139.

¹⁷⁷ A Buchanan, ‘Risk of Violence by Psychiatric Patients: Beyond the “Actuarial versus Clinical” Assessment Debate’ (2008) 59(2) *Psychiatric Services* 184, at p188; see also A. Buchanan, ‘Detention of People with Dangerous Severe Personality Disorders: a Systematic Review’ (2001) 358 *The Lancet* 1955.

¹⁷⁸ S.D. Hart *et al*, ‘Precision of Actuarial Risk Assessment Instruments: Evaluating the “Margins of Error” of Group versus Individual Predictions of Violence’ (2007) 190 (suppl49) *British Journal of Psychiatry* s60, at p.s61.

While risk is at the heart of MHA, the lack of a definition of the concept and the absence of conclusive guidance about what factors might be relevant in an assessment of it make it difficult to predict when and why decision-makers might deploy the compulsory powers. Even when they assess a patient with a view to admitting him to hospital, practitioners may complete any number of different risk assessments whose reliability and validity remain doubtful even in the so-called age of risk. This theoretically makes it possible for two patients with the same mental disorder to have wholly distinct care and treatment experiences under the MHA.

4. What Does the Case Law Tell Us About Risk?

4.1. Getting our Bearings

Risk is not unique to mental health law. According to Steele, the concept appears ‘extensively’ throughout legal theory, although it is rarely analysed in its own right.¹⁷⁹ A brief search of *Halsbury’s Laws of England* reveals thousands of references to risk in almost every conceivable area of the law. Despite its pervasiveness, the courts do not recognise a fixed definition of the concept. In this section, we analyse the courts’ position on risk and discuss the implications for mental health law.

It is important to point out that there is a conspicuous lack of case law directly addressing the interpretation of the MHA’s risk formula. Indeed, the courts may actually have further contributed to the confusion by referring to the risk formula in other ways,

¹⁷⁹ Steele, *supra* n.21, at p5.

e.g., the ‘safety test’.¹⁸⁰ In any event, where relevant cases do exist they typically emanate from the lower courts, meaning that there is always some doubt about whether their principles apply more broadly. On the face of it the courts have revealed very little about the mechanics of risk for the specific purposes of the MHA’s civil commitment powers.¹⁸¹

Yet, this does not tell the whole story. In truth, the superior courts *have* on occasions considered the risk formula, but mostly in relation either to Part III of the MHA, which concerns people with mental disorders involved in the criminal justice system, or to judicial review proceedings brought against the decisions of Mental Health Review Tribunals (MHRTs). While this thesis focuses narrowly on the risk formula as a criterion used by mental health professionals to *admit* patients with mental disorder to hospital under the civil commitment powers, there is no reason why case law relating to risk and the MHA more broadly cannot help us to gain an understanding of how the courts interpret the concept. In B v Scottish Ministers,¹⁸² the Scottish Court of Session read the Mental Health (Scotland) Act 1984 in accordance with an interpretive presumption which assumes that the legislature intends a particular phrase or term that appears in a single statute to have the same meaning throughout.¹⁸³ This is persuasive authority for the proposition that the courts will expect that the risk formula which appears throughout the similarly-worded English MHA will be interpreted consistently throughout the legislation. This means that if, for

¹⁸⁰ Reid v Secretary of State for Scotland [1999] 1 All ER 481, HL, *per* Lord Lloyd at 485. See also R v Canons Park Mental Health Review Tribunal, ex parte A [1994] 2 All ER 659.

¹⁸¹ This contrasts with the United States, where the courts have specified the substantive standards that decision-makers must meet if civil commitment is to be lawful. See, e.g., Lessard v Schmidt 39 F. Supp. 1078 (ED Wis. 1972).

¹⁸² [2010] CSIH 31.

¹⁸³ *Ibid*, at para.24.

example, a court were reviewing the MHRT's interpretation of the risk formula, it will presume that it has the same meaning as that which mental health professionals use to admit patients in the first place. Even if this were not followed by English courts, there is authority which suggests that the MHA should in any event be treated as a complete and comprehensive code governing compulsory admission to hospital for mentally disordered people.¹⁸⁴ It follows that the principles in the case law arising out of the MHA should not necessarily be limited to the specific provisions of the Act to which they pertain. This was reinforced by the case of R v North West London Mental Health NHS Trust, ex parte Stewart,¹⁸⁵ in which the Court of Appeal said that Parts II and III of the MHA are not mutually exclusive but rather contain powers which coexist. This means that the *rationes decidendi* of case law discussing the risk formula under Part III of the MHA will still be relevant to the interpretation of that same formula under Part II.¹⁸⁶ Similarly, in R (on the application of H) v Mental Health Review Tribunal,¹⁸⁷ Lord Phillips MR said that it is 'axiomatic' that if the MHRT's function is to consider whether the detention of a patient is lawful, 'it must apply

¹⁸⁴ R (on the application of Sessay) v South London and Maudsley NHS Foundation Trust [2011] EWHC 2617 (QB), *per* Supperstone J at para.34: 'We are of the view that the Mental Health Act provides a complete statutory code covering persons in the Claimant's position'. His Lordship rejected a submission that the common law plays a residual role in the MHA. The Sessay case relied on the Scottish case of B v Forsey [1998] SLT 572, in which the House of Lords made the same point in relation to the Mental Health (Scotland) Act 1984. C.f. R v Bournemouth Community and Mental Health Trust, ex parte L [1998] 3 WLR 107 (HL) in which their Lordships acknowledged the continuing application of the common law doctrine of necessity to informal patients outside the ambit of the MHA.

¹⁸⁵ [1997] 4 All ER 871, CA.

¹⁸⁶ It is noteworthy that the risk formula is worded differently in Part III of the MHA. For the Crown Court to impose a restriction order on a person with mental disorder under s.41 MHA, it must (i) have imposed a hospital order under s.37 MHA, and (ii) deem that person such a risk 'that *it is necessary for the protection of the public from serious harm*'. (Emphasis added).

¹⁸⁷ [2001] EWCA Civ 415.

the same test that the law required to be applied as a precondition to admission...¹⁸⁸ The MHA requires the MHRT to discharge a patient liable to be detained under section 3 if it is not satisfied, *inter alia*, that it is necessary for the health or safety of the patient or for the protection of other persons that he should receive treatment in hospital.¹⁸⁹ The provisions relating to patients' discharge from hospital therefore mirror those that provide the legal basis for their initial admission.¹⁹⁰ Lord Phillips' speech in the H case affirms that the MHRT effectively considers the same risk formula that mental health professionals do, albeit from a negative standpoint. This means that the myriad judicial review applications brought by patients challenging the decisions of the MHRT can shed some light on the courts' expectations more generally.

In light of the foregoing, the discussion that follows includes cases that arose from Part III of the MHA, judicial review challenges of MHRT decisions, and jurisprudence of the ECtHR, as well as relevant cases from other areas of domestic law. While the substance of these cases may not pertain to the definition of the risk formula in the civil commitment powers specifically, they are the closest thing we have to judge-made law on the issue. It is submitted that they provide a reliable signal of the likely outcome of litigation arising out of disputes about decision-makers' interpretations of the MHA's risk formula.

¹⁸⁸ *Ibid*, at para.31.

¹⁸⁹ MHA, s.72(1)(b)(ii). Because of the slight difference in the wording of the risk formula between sections 2 and 3, where a patient has been admitted for assessment for the purposes of s.2, s.72(1)(a)(ii) provides that the MHRT must direct his discharge if it is not satisfied that, *inter alia*, his detention is justified in the interests of his own health or safety or with a view to the protection of others.

¹⁹⁰ See also R v London South and South West Region Mental Health Review Tribunal, ex parte Moyle (2000) *The Times* 10 February.

4.2. The Definition Problem

4.2.1. Risk is Not a Legal Term of Art

Perhaps because they fear finding themselves ‘befogged’, the courts are reluctant to create terms of art for ordinary words appearing in legislation. In Brutus v Cozens,¹⁹¹ the House of Lords had to consider the meaning of the words ‘insulting behaviour’ in section 5 of the Public Order Act 1936 (as amended). On the facts of the case, the appellant interrupted play at the Wimbledon tennis tournament as part of a protest. He was arrested and charged under section 5 of the 1936 Act with using insulting behaviour likely to occasion a breach of the peace. While at first instance the justices had found that the appellant’s behaviour was not ‘insulting’, the Divisional Court defined ‘insulting behaviour’ as ‘behaviour which affronted other people and evidenced a disrespect or contempt for their rights, and which reasonable persons would foresee as likely to cause resentment or protest’. This wording did not appear anywhere in the 1936 Act. Allowing an appeal against this ruling, the House of Lords held that the question whether a person had used insulting behaviour for the purposes of section 5 was a matter of fact. Because there was no evidence to suggest that Parliament had intended the words ‘insulting behaviour’ to convey an unusual meaning, Lord Reid stated that their interpretation as ordinary words of the English language was not a question of law.¹⁹² If it were, His Lordship felt that the courts would ‘reach an impossible position’ in which they would have to define *all* the words that appear in statutory provisions.¹⁹³ The interpretation of the ordinary words would only become a

¹⁹¹ [1973] AC 854, HL.

¹⁹² *Per* Lord Reid, at 861.

¹⁹³ *Ibid.*

question of law where the tribunal has attributed an unnatural meaning which is so unreasonable that no tribunal acquainted with the ordinary use of language could reasonably have reached that decision.¹⁹⁴ Otherwise, unless a statutory definition limits or modifies the ordinary meaning of a word,¹⁹⁵ this is not a matter for the court.

The MHA and other mental health legislation are no exception to this rule; the courts have consistently preferred to give words their natural and ordinary meaning. In R (on the application of B) v Ashworth Hospital Authority,¹⁹⁶ the appellant had been detained under the original 1983 Act subject to a hospital order, which said that he was suffering from mental illness. Whilst in hospital, the patient was given personality tests which indicated that he also had psychopathic disorder. The appellant was transferred to a specialist psychopathy ward for treatment, although his hospital order was not amended to reflect this. The issue for their Lordships was whether a patient subject to the compulsory powers could be given medical treatment without his consent under section 63 for any mental disorder from which he was suffering or only for the specific condition for which he was detained. In giving the judgment of the court, Baroness Hale read the words of section 63 according to their natural and ordinary meaning and held that a patient could be given treatment for *any* mental disorder from which he is suffering regardless of the diagnosis which formed the initial basis for his detention.¹⁹⁷ Her Ladyship made it clear that when

¹⁹⁴ See also Bryan v Robinson [1960] 2 All ER 173, which concerned an unnatural interpretation of the words 'insulting behaviour' for the purposes of s.54(13) of the Metropolitan Police Act 1839. There are echoes here of *Wednesbury* unreasonableness, see Associated Provincial Picture Houses v Wednesbury Corporation [1947] 1 KB 223 and Council of Civil Service Unions v Minister for the Civil Service [1985] AC 374, HL.

¹⁹⁵ *Ibid.*

¹⁹⁶ [2005] UKHL 20.

¹⁹⁷ *Ibid.*, at para.22.

interpreting the MHA the court will give the words that make up its provisions their plain meaning. This interpretive presumption applies even to words which ostensibly imply a clinical or specialist meaning. In W v L,¹⁹⁸ the Court of Appeal considered the meaning of ‘mental illness’ for the purposes of section 26(2)(a)(i) of the Mental Health Act 1959, which did not define the term. Following Brutus, Lawton LJ said that the words ‘mental illness’ are ordinary words of the English language which carry no particular medical or legal significance. For that reason, the court should construe them in the same way that an ordinary, sensible person would.¹⁹⁹ W v L exhibits the courts’ long-standing antipathy towards the attribution of ‘legal’ meanings to clinical terms which might tie the hands of mental health practitioners.²⁰⁰ In Randall v Randall,²⁰¹ Merriman P declined to specify what degree of ‘unsoundness of mind’ was necessary for the purposes of the Matrimonial Causes Act 1937 ‘because to do so would serve no useful purpose and might create difficulties’.²⁰² Similarly, in Whysall v Whysall,²⁰³ a case concerning the definition of ‘incurably of unsound mind’ under section 1(1)(d) of the Matrimonial Causes Act 1950, Phillimore J said that ‘there is a great risk that in attempting to define words used by Parliament fresh difficulties will be created – the result may be to make confusion worse compounded’. It seems that the courts have preferred not to lay down legalistic glosses for words appearing in mental health legislation for fear of complicating the law.

¹⁹⁸ [1974] QB 711, CA.

¹⁹⁹ *Ibid*, at 719.

²⁰⁰ See, e.g., Lock v Lock [1958] 1 WLR 1248.

²⁰¹ [1939] P 131.

²⁰² *Ibid*, at 137.

²⁰³ [1960] P 52.

Although there is no case law in which the courts have explicitly stated that the term ‘risk’ must also be given its natural and ordinary meaning for the purposes of the MHA, it is safe to assume that the Brutus principle would apply here too. Where the courts have addressed the interpretation of ‘risk’ in other areas of the law, they have exhibited the same reluctance to prescribe a special meaning to the term. In Koonjul v Thameslink Healthcare Services,²⁰⁴ the Court of Appeal had to consider the meaning of ‘risk’ for the purposes of regulation 4(1) the Manual Handling Operations Regulations 1992.²⁰⁵ The claimant had suffered a back injury in the course of her employment as a care assistant. In the Court of Appeal, their Lordships dismissed the claimant’s appeal, agreeing with the first instance judge that there had not been a risk of injury to the claimant sufficient to engage the regulations. Hale LJ said that for the purposes of regulation 4(1), there must be a ‘real’ risk, which Her Ladyship defined as ‘a foreseeable possibility of injury; certainly nothing approaching a probability’.²⁰⁶ In framing this construction, Her Ladyship relied on the *dictum* of Aldous LJ in Hawkes v London Borough of Southwark²⁰⁷ and the Scottish case of Cullen v North Lanarkshire Council.²⁰⁸ While the Court of Appeal in Koonjul appeared to specify a ‘risk standard’, it is important to remember that this applied only to the Manual Handling Operations Regulations. There is nothing in the case to suggest that their Lordships had

²⁰⁴ [2000] PIQR 123, CA.

²⁰⁵ SI 1992/2793.

²⁰⁶ *Per* Hale LJ, at 126.

²⁰⁷ Unreported, 1998.

²⁰⁸ [1998] SC 451.

intended their definition to have a broader application in law.²⁰⁹ In fact, it seems that the courts have occasionally been prepared to define 'risk', but only on a specific case-by-case basis.²¹⁰ For the most part, however, judges place the same emphasis on applying natural and ordinary meanings to 'risk' that they do to any other words or phrases. In Letting International Limited v Newham London Borough Council²¹¹ the High Court had to consider the interpretation of the word 'risk', this time in relation to regulation 47(6) of the Public Contracts Regulations 2006.²¹² Here, Silber J relied on the definition given by the Shorter Oxford English Dictionary: 'there must be a possibility of damage because the word "risk" means... "the chance or hazard of commercial loss"'.²¹³ His Lordship thereby gave 'risk' its natural and ordinary meaning as it appeared in the dictionary.

It is submitted that the courts would do the same for 'risk' as it appears in the MHA, and also for the words that constitute the risk formula. This presumably explains why Harrison J chose a common sense construction of the risk formula's reference to 'the protection of other persons' in R v North West London Mental Health NHS Trust, ex parte Stewart.²¹⁴ Yet, here we encounter a key reason why the prominence given to risk by the MHA is problematic from a legal point of view: if we cannot agree on the ordinary meaning of 'risk'

²⁰⁹ This construction was later applied in Alsop v Sheffield City Council [2002] EWCA Civ 429 and Bennetts v Ministry of Defence [2004] EWCA Civ 486, which both concerned the Manual Handling Operations Regulations 1992.

²¹⁰ See, e.g., the Victorian case of Stokes v Cox (1856) 156 ER 1225, in which the court had to consider what might amount to a 'special risk' for the purposes of a contract of insurance between the plaintiff and the defendant.

²¹¹ [2008] EWHC 1583, QB

²¹² SI 2006/5.

²¹³ *Per* Silber J, at para.136.

²¹⁴ *Supra* n.185. His Lordship said that the phrase 'does not necessarily mean the public at large because it could simply relate to an individual person or persons'.

generally, the courts' insistence on employing a natural interpretation of the words in the MHA might not actually be an expedient solution at all.

4.2.2. Risk is a Divisible Concept

To further compound the uncertainty, the courts can treat 'risk' as a divisible concept. Instead of regarding risk in binary terms the courts use a sliding scale. We have already seen in Koonjul that Hale LJ modified the word 'risk' by using the adjective 'real' to clarify the point at which a defendant's acts or omissions might engage the Regulations. The practical effect of Her Ladyship's approach was to distinguish 'ordinary' and 'real' risks; while the former may place moral pressure on decision-makers only the latter are actionable in law.

On one hand this divisibility makes intuitive sense. In chapter two we saw that modern society is defined by the risk paradigm so that almost anything can be described as either 'a risk' in itself or 'at risk' from some extraneous hazard. By distinguishing high and low risks, the courts implicitly accept that not every risk can or should be addressed. Some outcomes are more likely to occur than others, and, if they do, they are more likely to be catastrophic in their effects. Treating risk as a divisible concept is therefore a pragmatic solution which accommodates the variable likelihood and gravity of the risks at issue. On the other hand, this exacerbates the difficulties we have in defining 'risk', particularly for the purposes of the MHA. First, a prerequisite for treating risk as a divisible concept must surely be an established frame of reference against which higher or lower risks can be measured: there must be a fixed standard of risk from which to depart. If we do not know what 'risk' means, how is one expected to distinguish between, say, high and low risks? Indeed, it raises even more questions about what amounts to an actionable risk in law; for example, Hale LJ's reference to 'real' risk in Koonjul's case immediately raises questions about how it differs

from 'ordinary' risk. What effect modifiers like 'static',²¹⁵ 'serious',²¹⁶ and 'low' and 'high'²¹⁷ are supposed to have on 'risk' is equally vague. Secondly, it is not clear whether the MHA's detention criteria recognise anything other than an indivisible conception of risk. Save for a small difference in the wording between sections 2 ('in the interests of...') and 3 ('necessary for...'), the MHA makes no distinction between a patient who has a high risk of suicide and a patient with a comparatively low risk of taking his own life. A literal reading of the legislation suggests that *both* are equally liable to face compulsion under the Act, thereby rendering the divisibility of risk redundant.

In spite of these theoretical shortcomings, the courts have demonstrated a propensity to treat risk as a divisible concept in mental health cases. This tendency has been most apparent on occasions in which patients have contended that their right to life under Article 2 ECHR has been contravened. Article 2 provides that everyone's right to life shall be protected by law. According to Convention jurisprudence a State Party will be subject to a *positive* obligation actively to protect a person's right under Article 2 where there is a 'real and immediate risk' to his life.²¹⁸ In Re Officer L,²¹⁹ the House of Lords said that the threshold for a 'real and immediate' risk is high: 'a real risk is one which is objectively verified and an

²¹⁵ See, e.g., R (on the application of PP) v Secretary of State for Justice [2009] EWHC 2464 (Admin), where the evidence referred to the applicant's 'static' risk.

²¹⁶ See, e.g., R v Ronald Lonford Golding [2006] EWCA Crim 1965, where the Court of Appeal considered whether a sentencing judge had been right to conclude that the applicant posed a risk of 'serious' harm when he imposed hospital and restriction orders on him for the purposes of ss.37 and 41 MHA.

²¹⁷ See, e.g., Savage v South Essex Partnership NHS Foundation Trust [2009] 1 AC 681, where Lord Rodger, at para.50, discusses the significance of the distinction between 'low' and 'greater' risk.

²¹⁸ LCB v United Kingdom (1999) 27 EHRR 212; Osman v United Kingdom (2000) 29 EHRR 245.

²¹⁹ [2007] UKHL 36.

immediate risk is one which is present and continuing'.²²⁰ This means that patients held in hospital under the MHA²²¹ or engaging with mental health services voluntarily²²² who pose a real and immediate risk to themselves require a higher level of care and supervision than those who do not pose such risk. State Parties can therefore be less exacting with those patients who they have deemed to pose an 'ordinary' risk, even where doctors have recommended that more intensive care and treatment is indicated.²²³ Here again we see the courts putting the cart before the horse: if they will not specify what an ordinary risk is, how are they supposed to judge whether a risk is real or immediate? This is a particularly crucial point given that patients detained in hospital under the MHA will *already have been deemed to pose a risk sufficient to justify their admission in the first place*. For example, in Savage's case the patient had paranoid schizophrenia and was admitted to hospital for treatment under section 3. She subsequently absconded and committed suicide. The House of Lords held that the defendant hospital trust had breached its operational obligation to Mrs Savage under Article 2 because (i) it knew or ought to have known that there was an real and immediate risk of the patient committing suicide, and (ii) the medical authorities failed to do all that reasonably could be expected of them to prevent it. Yet, while the 'real and immediate' standard is clearly intended to distinguish the risks which engage the protection of Article 2 from those that do not, its utility is questionable given that it sheds no light on what actually characterises an 'ordinary' risk. Mrs Savage was presumably deemed to pose

²²⁰ *Ibid*, per Lord Carswell, at para.20. See also In Re Weatherup [2004] NIQB 67.

²²¹ Savage's case.

²²² Rabone v Pennine Care NHS Foundation Trust [2012] UKSC 2.

²²³ See, e.g., R (on the application of P) v Secretary of State for Justice [2009] EWCA Civ 701, where a person with mental disorder who was on remand and was repeatedly and seriously self-harming was deemed *not* to pose an immediate risk and therefore the state was not subject to a positive obligation under Article 2 when it failed to move him to appropriate accommodation.

such an ordinary risk to herself that she warranted detention in hospital, but the court requires more than that to impose a positive obligation on a State Party under Article 2. Yet, because the court does not define 'risk', where the thresholds for compulsion under the MHA and positive obligations under the ECHR actually lie is anyone's guess.

These difficulties of definition represent the first part of the problem that the concept of risk poses for lawyers. Without an agreed definition of 'risk', the concept's prominence in the MHA is problematic. Despite its ubiquity in legal theory, 'risk' is not a term of art. For that reason, the courts will interpret the term according to what they believe is its natural and ordinary meaning. To complicate the matter further, they are prepared to modify risk despite having no agreed frame of reference from which to depart. It seems that while the language of risk pervades mental health law and policy, there is no agreement about what the concept actually means.

4.3. The Evidential Problem

4.3.1. Risk is a Matter of Fact

By omitting a definition of 'risk', the MHA leaves the issue of interpreting it to mental health professionals. It follows that what amounts to an actionable risk is a matter of fact. This raises another problem: what evidence will be probative of risk? The Act and its accompanying Code of Practice say very little on this point.

The courts are not typically concerned with whether a decision is right or wrong;²²⁴ they will only intervene where it is unlawful.²²⁵ In medical cases judges have been particularly

²²⁴ R v Somerset County Council, ex parte Fewings [1995] 1 All ER 513, *per* Laws LJ at 515.

²²⁵ Council of Civil Service Unions v Minister for the Civil Service [1985] AC 374, HL.

reluctant to presume any competence in the clinical domain. In R (on the application of Khela) v Brandon Mental Health Unit,²²⁶ Thornton J said that the court was not able to second-guess clinicians because ‘there is currently no remedy available that enables the court to order that the diagnosis of a doctor should be changed and corrected.’²²⁷ This judicial respect for the limits of professional competences makes sense: judges are simply not qualified to say whether a doctor’s decision is right or wrong. For that reason, they tend to defer to clinical opinion. This is particularly true in the tort of negligence, in which the standard of care a doctor must discharge when treating his patients is that of the ordinary skilled man (or woman) exercising and professing to have that special skill.²²⁸ The same standard applies equally to psychiatrists.²²⁹ This means that the court will judge a doctor’s actions against his own professional standards. If a doctor (or psychiatrist) falls beneath the standard of care, the court will find that he is in breach of his duty. Otherwise, judges are not prepared to evaluate the merits of clinical decisions.²³⁰

A similar theme is evident in the courts’ pronouncements on decision-making under the MHA. To a certain extent, this arm’s length approach is a product of the legislation. The

²²⁶ [2010] EWHC 3313 (Admin)

²²⁷ *Ibid*, at para.6.

²²⁸ See Bolam v Friern Hospital Management Committee [1957] 1 WLR 582, *per* McNair J at 586; Whitehouse v Jordan [1981] 1 All ER 267, HL; Maynard v West Midlands Regional Health Authority [1985] 1 All ER 635, HL; Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1985] AC 871, HL.

²²⁹ G v Central and North West London Mental Health Authority [2007] EWHC 3086 (QB).

²³⁰ Although see also Bolitho v City and Hackney Health Authority [1998] AC 232, HL, in which the House of Lords said that the courts will apply the Bolam standard, except in circumstances where the practices of a responsible body of medical opinion defy logic. The Court of Appeal applied Bolitho’s case to psychiatric practices in Dunn v South Tyneside Health Care NHS Trust [2003] EWCA Civ 878.

MHA insulates mental health professionals from any civil or criminal proceedings in respect of acts they purport to do in pursuance of the legislation, unless such acts are done in bad faith or without reasonable care.²³¹ Even then, a patient cannot bring civil proceedings against any person in any court in respect of any such act without the leave of the High Court.²³² According to Lord Bingham in Seal v Chief Constable of South Wales Police,²³³ these provisions were introduced with the obvious object of giving mental health professionals greater protection from litigation than they had enjoyed in the past.²³⁴ The courts are therefore even less likely to reconsider doctors' decisions under the MHA than they might be in other areas of medical practice. Even when they do hear such cases, judges are reluctant to review practitioners' decisions. In Savage's case, Lord Rodger explained that 'the level of risk for any particular patient [can] be expected to vary with fluctuations in his or her medical condition... Such decisions involve clinical judgement. Different doctors may have different views'.²³⁵ His Lordship plainly took the view that the courts are in no position to decide how people with a mental disorder should be treated under the MHA. Similarly, in R v North West Thames Mental Health Review Tribunal, ex parte Cooper,²³⁶ Rose J said that the courts would be reluctant to interfere with the decision of the MHRT unless there was a

²³¹ MHA, s.139(1).

²³² MHA, s.139(2). Although it seems that the threshold is quite low: DD v Durham County Council [2013] EWCA Civ 96.

²³³ [2007] UKHL 37.

²³⁴ The ECtHR later confirmed that this requirement to seek leave was compatible with the right to a fair trial under Article 6(1) ECHR (Seal v United Kingdom [2010] ECHR 50330/07).

²³⁵ Savage's case, per Lord Rodger at para.50.

²³⁶ (1990) 5 BMLR 7.

basis for a challenge on a well-known line, e.g., the decision was unreasonable.²³⁷ While their decisions can lead to the deprivation of patients' liberty, it seems that mental health practitioners may deploy the MHA's compulsory powers with only a low level of oversight by the courts.

The upshot of this is that there is no universal calculus of risk against which judges can gauge the decisions of mental health practitioners.²³⁸ In fact, the courts refuse to specify the ingredients that might justify a decision-maker's conclusion that a patient poses a risk.²³⁹ This gives them a wide discretion under the MHA; decision-makers can recast almost anything to do with the patient's disorder, characteristics or circumstances as evidence of risk. Yet, is there a limit to this discretion?

4.3.2. Anything Goes?

Mental health decision-makers act in a quasi-judicial capacity. In the same way that a judge must interpret and apply a piece of legislation in order to give effect to the intentions

²³⁷ *Ibid*, per Rose J at 13.

²³⁸ See, e.g., United States v Carroll Towing Company 159.F2d 169 (2nd Cir. 1947). In this case, Learned Hand J said that the extent of a defendant's duty to guard against the risks of injury, loss or damage in tort law is a function of three variables: (i) the probability of an adverse event (*P*), (ii) the gravity of the resulting injury (*L*), and (iii) the burden of taking adequate precautions (*B*). A defendant is only liable where the burden of taking precautions is less than the gravity of the resulting injury multiplied by the probability of an adverse event, or $B < (PL)$. English courts have not adopted this calculus, presumably because the Hand variables are difficult to quantify in practice. Instead, the court establishes the extent of a defendant's duty on the facts of the case. In Watt v Hertfordshire County Council [1954] 2 All ER 368, CA, Denning LJ, at 371, said that when determining whether a defendant is in breach of duty 'it is always a question of balancing the risks against the end'.

²³⁹ See, e.g., R (on the application of Von Brandenburg) v East London and the City Mental Health NHS Trust [2004] 2 AC 180, per Lord Bingham at para.10; R v Parole Board, ex parte Bradley [1990] 3 All ER 828 (QB); R (on the application of K) v West London Mental Health Trust [2006] EWCA Civ 118 in which the Court of Appeal said that the weight to be given to the opinion of a responsible medical officer about how his patient should be treated depends on all the circumstances of the case, which Dyson LJ declined to define exhaustively.

of Parliament, mental health professionals must read and give effect to the MHA. Yet they differ in an essential way: if a judge in ordinary civil proceedings had to determine whether a person with mental disorder should be admitted to hospital under section 3 he would have to be satisfied by cogent evidence that, on a balance of probabilities, the conditions for the patient's detention were met.²⁴⁰ Mental health decision-makers, by contrast, are not obliged to adhere to the same standard. Although they have to comply with the MHA, practitioners ultimately take a *clinical* decision, which, by definition, entails distinct considerations from those that underpin judicial rulings.²⁴¹ In R (on the application of AN) v Mental Health Review Tribunal (Northern Region),²⁴² the Court of Appeal distinguished the judicial standard which the MHRT must follow from the less exacting clinical standard expected of mental health practitioners. Decision-makers do not therefore need to establish that a patient is a risk to himself or others on the balance of probabilities. According to Richards LJ, in matters of judgement and evaluation, the standard of proof is not particularly helpful; in fact, slavish adherence to it would probably undermine the scheme of the MHA.²⁴³ His Lordship agreed with Lord Hoffman in Secretary of State for the Home Department v Rehman,²⁴⁴ who said that the question of risk 'depends upon an evaluation of the evidence of the appellant's conduct against a broad range of facts with which they may interact'. Lord Hoffman said that whether someone poses a risk cannot be answered 'by taking each allegation seriatim and deciding whether it has been established to some

²⁴⁰ See, e.g., Miller v Minister of Pensions [1947] 2 All ER 372, KB, *per* Lord Denning at 373-4; Bonnington Castings Limited v Wardlaw [1956] AC 613, HL.

²⁴¹ R (on the application of H) v Oxfordshire Mental Healthcare NHS Trust [2002] EWHC 465 (Admin).

²⁴² [2005] EWCA Civ 1605.

²⁴³ *Ibid*, *per* Richards LJ at para.75.

²⁴⁴ [2001] UKHL 47.

standard of proof. It is a question of *evaluation and judgment*...²⁴⁵ In other words, questions of risk are not amenable to the rigours of judicial standards of proof.

There may be sound reasons for this. In R v Parole Board, ex parte Bradley,²⁴⁶ the court had to consider how much risk was required to meet a threshold at which people sentenced to life imprisonment could have their terms extended to protect the public. Stuart-Smith LJ declined to specify what might amount to a risk in the abstract, insisting that it is impossible to quantify risk in the same way as the court establishes the likelihood that something will or will not occur, i.e., on a balance of probabilities.²⁴⁷ Risk implies a different standard from likelihood; for example, we can talk of things posing a risk even when they are unlikely to occur. For that reason, the court in ex parte Bradley was prepared only to say what would *not* amount to a risk. Stuart-Smith LJ said that a risk that is merely perceptible or minimal will not be sufficient; it must be such that it is unacceptable according to the subjective judgement of the decision-maker.²⁴⁸ That was as far as His Lordship was prepared to go; there are so many factors that might be indicative of risk that they cannot all be enumerated in the abstract.²⁴⁹

²⁴⁵ *Ibid*, per Lord Hoffman, at para.56. Emphasis added.

²⁴⁶[1990] 3 All ER 828.

²⁴⁷ See, e.g., Hotson v East Berkshire Area Health Authority [1987] 2 All ER 909 (HL); Gregg v Scott [2005] UKHL 2.

²⁴⁸ Ex parte Bradley, at 838.

²⁴⁹ There is a parallel here with the tort of negligence. A defendant's conduct is measured against the standard of a hypothetical 'reasonable' man, which is objective (see Blyth v Birmingham Waterworks Co (1856) 11 Exch. 781; Glasgow Corporation v Muir [1943] AC 448, HL; Nettleship v Weston [1971] 2 QB 691, CA). Whether a defendant meets that standard is a question of fact, not law (Qualcast (Wolverhampton) v Haynes [1959] AC 743, HL). In the same way that it is impossible for the courts to set out *every* risk factor or combination of factors that will discharge the MHA's risk formula, the law cannot anticipate *all* the circumstances in which a defendant will fall beneath the standard of care. This is something that can only ever be determined on a case-by-case basis: a defendant's breach

A mental health decision-maker apparently does not have to have cogent evidence that a person with mental disorder is likely to pose a threat to his own health or safety or to others before he can detain that person under the MHA. It is enough that the patient poses a risk in his subjective evaluation and judgement. Essentially, this means that the point at which a patient may be detained under the MHA is even *lower* than the civil standard of proof. In addition to this, the MHA allows decision-makers to deploy the compulsory powers *before* a person with mental disorder has posed, or is certain to pose, an *actual* threat to his health or safety or to others.²⁵⁰ It follows that even the evidential burden is lower than it would be if the law demanded at least that the patient be *likely* to harm himself or others. This point was confirmed by R (on the application of MM) v Secretary of State for the Home Department,²⁵¹ in which the Court of Appeal considered an appeal brought by a patient with paranoid schizophrenia and a long history of engagement with mental health services. He had been convicted of an offence contrary to section 20 of the Offences Against the Person Act 1861 and had been placed on hospital and restriction orders for the purposes of sections 37 and 41 of the MHA respectively. While his mental disorder was ordinarily stable, the evidence suggested that the appellant's use of illicit drugs created a risk that his condition would deteriorate. For that reason, the Secretary of State recalled him to hospital

might turn on, e.g., his knowledge of the risks (Roe v Ministry of Health [1954] 2 QB 66, CA); the severity of the harm (Paris v Stepney London Borough Council [1951] AC 367, HL); how practicable it might have been for him to take precautions (Latimer v AEC Limited [1953] AC 643, HL); common practice (Morris v West Hartlepool Steam Navigation Company Limited [1956] AC 552, HL); or industry standards (Stokes v Guest, Keen and Nettlefold (Bolts and Nuts) Limited [1968] 1 WLR 1776).

²⁵⁰ There are parallels here with the notion of 'pre-crime', albeit in a civil context. See P. K. Dick, *Minority Report*, London: Gollancz, 2002; J. McCulloch and S. Pickering, 'Pre-crime and Counter-terrorism: Imagining Future Crime in the "War on Terror"' (2009) 49 *British Journal of Criminology* 628.

²⁵¹ [2007] EWCA Civ 687.

under section 42 MHA. The appellant challenged this decision, arguing that in order for his recall to be legitimate his medical team had to prove either that he had psychotic symptoms or that he was certain to have such symptoms in the immediate future. The Court of Appeal disagreed: Toulson LJ said that the logical corollary of this submission would mean that a doctor who thought that a mentally disordered patient posed a risk would be prevented from recalling him to hospital *unless* he was *certain* that harm would ensue. His Lordship reaffirmed that the point at which a patient's risks make his detention for treatment appropriate 'may involve a difficult judgment *on the facts of a particular case*'.²⁵² However, it would neither make sense nor comport with the policy underpinning the MHA if the courts were to read a high evidential burden into the risk formula.²⁵³ It is true that the only way a decision-maker can be *certain* that a patient actually is a risk to himself or others is to decline to intervene in his case. If the harm then materialises, it follows that the assessment of risk was accurate – this is what the Court of Appeal has previously called 'the proof of the pudding principle'.²⁵⁴ Yet this would represent an absurd distortion of the MHA, whose mechanics are geared towards avoiding or minimising risks of harm in the first place. For that reason, there must be a distinction between the *certainty* of harm and the *risk* of harm;

²⁵² *Ibid.*, at para.50. Emphasis added.

²⁵³ *Ibid.*, at paras.47-8.

²⁵⁴ R (on the application of H) v Ashworth Special Hospital Authority [2002] EWCA Civ 923, *per* Dyson LJ at para.59. A good example of this can be found in the facts of Barker v Barking, Havering and Brentwood Community Healthcare NHS Trust (Warley Hospital) [1999] 1 FLR 106. Here, the patient challenged a decision to renew her detention under s.20 MHA. She contended that because she was allowed extensive leave from the hospital under s.17 and the only treatment she was receiving for her mental disorder did not actually require compulsory admission to hospital, her detention was unlawful. Her doctor thought she was at a high risk of a relapse induced by her misuse of illicit drugs. Shortly after bringing her challenge, the patient took amphetamines whilst on leave from hospital and was readmitted suffering from drug-induced psychosis. In doing so, the patient vindicated her clinical team's initial assessment.

the former implies a high evidential threshold, whereas in the case of the latter it is enough that there is a *chance* that such harm *may* occur – a lower standard.

It is clear that mental health decision-makers do not have to be sure that a patient poses a risk before they can deploy the MHA's compulsory powers. Nor, indeed, does the risk even have to be *likely* to materialise. It is enough that on a practitioner's subjective evaluation and judgement he has concluded that the patient warrants compulsion under the Act. Furthermore, the evidence on which that conclusion is based does not even have to be particularly cogent. On one hand, this reflects the scheme of the legislation and ensures that mental health services are responsive to risks. On the other hand, it imposes very few limits on decision-makers' discretion, legitimising a person's detention in hospital on a fairly insubstantial basis. It should come as no great surprise that decision-makers have relied on feeble evidence to justify the deployment of the compulsory powers, for example, they may use the same 'risk is risk' paradox which appears in the Code of Practice to certify that it is necessary to detain a patient. What perhaps is more worrying is that the courts do not appear to object to decision-makers' descriptions of 'risk' in these circular terms; indeed, they may even be complicit in this practice. In W Primary Care Trust v TB (An Adult by her Litigation Friend the Official Solicitor) and Others,²⁵⁵ Roderick Wood J set out the factors that had led the consultant psychiatrist to the conclusion that the patient, who had chronic delusional disorder, posed a risk to herself and others. His Lordship said that 'there was a risk of suicide... and there was a further risk of exploitation of her by others given her general behaviour towards strangers'.²⁵⁶ Similarly, in R (on the application of GP) v Derby

²⁵⁵ [2009] EWHC 1731 (Fam).

²⁵⁶ *Ibid*, per Roderick Wood J, at para.18.

City Council,²⁵⁷ Pelling J accepted evidence from the patient's clinical team that he presented a risk to himself and others because he 'was at risk that his mental health would further deteriorate if he was discharged from hospital'.²⁵⁸ At no point did the judges in these cases comment on the potential fallacy that lies in describing 'risk' with reference to other risks. Not only does this exacerbate the difficulties of definition but it also makes it hard to discern what evidence is actually underpinning the doctor's conclusion. Do the evidential factors have to point to the risk of *harm*? Or is it enough that there is only a *risk* of a risk of harm? And how many levels of abstraction are permissible? The fact that the courts seem willing to allow decision-makers to base their assessments of risk on a house of cards of other, smaller risks suggests that the evidential threshold is very low.

A seemingly unrestricted number of factors can apparently support the conclusion that a patient is a risk and thereby justify his compulsory admission to hospital. This is further amplified by the fact that the issue of risk may not be an exclusively clinical one. In a number of judicial review cases, the courts have said that MHRTs can reject clinical evidence which suggests that a patient is no longer a risk.²⁵⁹ In other words, a patient's risk profile is detachable from his mental disorder. In R v Mental Health Review Tribunal, ex parte Pickering,²⁶⁰ Forbes J suggested that an MHRT may have compelling policy reasons for

²⁵⁷ [2012] EWHC 1451 (Admin).

²⁵⁸ *Ibid*, at para.23.

²⁵⁹ See, e.g., RH v South London and Maudsley NHS Foundation Trust [2010] EWCA Civ 1273; R (on the application of Munday) v Secretary of State for the Home Department [2009] All ER (D) 96 (Admin); R (on the application of OS) v Secretary of State for the Home Department [2006] EWHC 1903 (Admin);

²⁶⁰ [1986] 1 All ER 99.

rejecting clinical evidence that a patient is not a risk to himself or others.²⁶¹ Moreover, in R v Trent Mental Health Review Tribunal, ex parte Ryan,²⁶² it was held that the definition of some terms in the MHA is not solely a clinical issue. Consequently, there is apparently nothing which expressly prohibits decision-makers from taking non-clinical considerations into account when assessing risk. The cumulative effect of this is that practitioners can justify their decisions to deploy the compulsory powers on the basis of evidence which may be either tentative or tangential.

4.3.3. Procedural Guidance

It is not the case, however, that decision-makers have *carte blanche* to recast *anything* as conclusive evidence of risk. The courts have imposed at least *some* limits. First, decision-makers may not be able to conclude that a patient poses to risk to himself or others solely on the basis of his clinical history. In R (on the application of Jones) v Isleworth Crown Court,²⁶³ the High Court dismissed an application for judicial review of the Crown Court's decision that the claimant presented a risk of serious harm to the public and therefore should be subject to a restriction order for the purposes of section 41 MHA.²⁶⁴ While there was no dispute that the claimant, who had paranoid schizophrenia, posed a risk to the public, the issue was whether he deserved special restrictions. It was submitted on his behalf that the evidence the judge had heard suggested his risk profile did not warrant a

²⁶¹ *Ibid*, at 101.

²⁶² [1992] COD 157.

²⁶³ [2005] EWHC 662 (Admin).

²⁶⁴ MHA, s.41(1) allows the Crown Court to subject an offender to special restrictions where (i) he has been given a hospital order under s.37, and (ii) the court believes that it is necessary for the protection of the public from serious harm.

restriction order. Moses J found that the judge had in fact been quite entitled to impose a restriction order in light of the medical evidence. However, His Lordship stressed that assessments of risk for the purposes of section 41 require the judge to look to the future. Moses J said that the judge was 'bound to consider the risk in the future and the nature of that risk... but he was not bound to determine that risk solely by reference to the nature of the violence in the past'.²⁶⁵ If we apply this principle to the MHA more broadly, it would suggest that mental health practitioners must rely on contemporary evidence that compulsion is necessary in the interests of the patient's health or safety or with a view to the protection of other people *because of some harm that may occur in the future*. While a patient's clinical history may have some predictive value, it must not have a prejudicial effect. For a decision-maker simply to conclude that a patient has posed a risk in the past and therefore is likely to do so again in the future will not suffice.

Secondly, although the MHA does not specify the factors that might be probative of risk, this does not mean that decision-makers can simply pay lip service to the concept. There must at least be *something* to support a decision-maker's conclusion that a patient poses a risk. In Bone v Mental Health Review Tribunal,²⁶⁶ the appellant had been convicted of manslaughter on the grounds of diminished responsibility and was subject to an indefinite restriction order under section 41. He applied to the MHRT for release under section 73(1)(a), which states that the tribunal should discharge a patient absolutely if it is not satisfied, *inter alia*, that the patient's continued detention is necessary for the health or safety of the patient or for the protection of other persons. The MHRT ruled that the

²⁶⁵ Jones' case, per Moses J at para.19

²⁶⁶ [1985] 3 All ER 330, QB.

appellant should not be discharged, although it offered no substantive reasons to support this conclusion. Nolan J said that the MHRT was under a duty to provide reasons for its decision; by failing to do so, it had committed a procedural error. It was not enough for the MHRT simply to restate the risk formula as it appears under section 73(1)(a) as the nominal reason for its decision. Applying this principle more broadly, it seems likely that the courts will expect at least *some* reasons if a decision to admit a patient to hospital under the MHA is to be legitimate. A similar issue arose in R v Mental Health Review Tribunal, ex parte Clatworthy.²⁶⁷ Here, the applicant had been subject to a restriction order for five years following his conviction for sexual assault. In 1984, the applicant's doctor referred his case to the MHRT, contending that there was no evidence that he was suffering from a mental disorder which warranted detention in hospital. The tribunal refused to discharge the patient but, instead of providing reasons, merely restated the statutory criteria. Mann J found that the MHRT's reasons had amounted to a 'bare traverse' of the circumstances in which discharge could be contemplated.²⁶⁸ His Lordship said that the MHRT's reasons would not make it clear to the applicant why the case advanced on his behalf had not been accepted. The MHRT's ruling was quashed. Clatworthy's case shows the value that the courts place on legal certainty; patients should know where they stand during the course of their engagement with mental health services. This means that decision-makers are precluded from reaching decisions which are devoid of any justification.²⁶⁹ There must be *something* to support a mental health practitioner's recommendation that a patient be

²⁶⁷ [1985] 2 All ER 699, QB.

²⁶⁸ *Ibid*, at 703-4.

²⁶⁹ See also R (on the application of East London and the City Mental Health NHS Trust) v Mental Health Review Tribunal [2005] EWHC 2329 (Admin); R (on the application of the Secretary of State for the Home Department) v Mental Health Review Tribunal [2005] EWHC 746 (Admin).

admitted to hospital for assessment or treatment, even though it does not have to discharge a particularly onerous evidential or legal burden.²⁷⁰

The Court of Appeal considered this point in R v Birch.²⁷¹ Here, the appellant had been made the subject of a restriction order, despite the fact that his doctors did not think it was necessary and there was no other evidence to indicate the need for special restrictions. While the wording of section 41(1) confers on the courts the discretion to impose restriction orders without reference to clinical evidence, the Court of Appeal held that this does not mean that the courts can impose them without any evidence at all. According to Mustill LJ, the only thing that the court had to go on in Birch's case was the evidence of the doctors; consequently, there was nothing to support the court's decision that special restrictions were necessary for the protection of the public from serious harm. While this is a slightly different risk formula from that which applies under section 3, it is submitted that the essential point that decisions to deprive a patient of his freedom must have an evidential basis remains applicable.

Thirdly, while mental health decision-makers are not bound by the same standards as judges, it appears that their decisions should still at least be relevant and contemporary. In R (on the application of Li) v Mental Health Review Tribunal,²⁷² the MHRT had taken the applicant's general attitude to women into account when refusing his application for conditional discharge. The court held that this was an irrelevant consideration which bore

²⁷⁰ See R (on the application of W) v Mental Health Review Tribunal [2002] All ER (D) 300 (Apr), where it was held that an MHRT's reasons can be brief as long as they reflect the nature and context of the evidence.

²⁷¹ (1990) 90 Cr. App. R. 78.

²⁷² [2004] EWHC 51 (Admin).

no relationship to the possibility that the patient might fail to take his medication or reoffend. If this principle applies beyond the MHRT, decision-makers cannot base their recommendations to admit a patient to hospital on irrelevant factors. In the Scottish case of AB and CB v E and Others,²⁷³ the issue arose out of the similarly-worded discharge provisions of the Mental Health (Scotland) Act 1984. It was held that a patient's discharge could only be refused where this course of action is *actually*, and not merely *potentially*, necessary for his health or safety or for the protection of others. While this case is merely persuasive, there is no reason why the courts in England and Wales would not take a similar position should this point ever be contested here. This would mean that the evidential burden would be more exacting than the discussion in part 4.3.2 above suggests, albeit still lower than the civil and criminal standards of proof.

The cases show that the courts tend to steer clear of prescribing the factors that are to be conclusive of risk for the purposes of the MHA. Where the judiciary has expressed a view, it has typically done so on procedural grounds. For that reason, we know that the risk formula implies a lower evidential threshold, allowing decision-makers leeway when assessing patients' risks. We also know that practitioners should not allow a patient's clinical history to prejudice their assessments and that there must at least be *something* to discharge the risk formula. Beyond these pointers, the courts seem happy to leave the question of risk to mental health professionals. For that reason, we do not know what combination of risk factors will trigger the compulsory powers. We must assume instead that the courts do not have any such pre-set expectations: the presence or absence of risk

²⁷³ [1987] SCLR 419.

may thus depend on a *balance* between the oft-competing interests of the patient's liberty and the public's safety.²⁷⁴

An illustration of this type of balancing exercise is W v Egdel.²⁷⁵ Here, the plaintiff, who had paranoid schizophrenia, sought a transfer from a secure hospital to a regional mental health unit. To support his application, the plaintiff instructed the defendant psychiatrist to complete a report on his current condition for the MHRT. The defendant duly completed a report, which concluded that W had a continuing interest in bombs and other explosives and was not at all favourable to the plaintiff, who withdrew his application for a transfer. The defendant, fearing that his conclusions about the plaintiff would therefore be overlooked, sent his report to W's medical officer and the Department of Health. The plaintiff sought an injunction to prevent the defendant from disclosing the report and claimed delivery up of all copies. In the Court of Appeal, Bingham LJ said that Egdel's case required 'a careful balance between the legitimate desire of the patient to regain his freedom and the legitimate desire of the public to be protected against violence'.²⁷⁶ The court held that a doctor's duty of confidence is a matter of public interest, which must be balanced against the need to protect the public from violence committed by people with mental disorders. As the defendant's report contained relevant information which might

²⁷⁴ The courts are particularly keen to emphasise that mental health law seeks 'to regulate the circumstances in which the liberty of persons who are mentally disordered may be restricted and, where there is conflict, to balance their interests against those of public safety'. See R v Secretary of State for the Home Department [1990] 1 WLR 168, HC *per* McCullough J at 174.

²⁷⁵ [1990] Ch. 359, CA.

²⁷⁶ *Ibid*, *per* Bingham LJ at 418-9.

have a bearing on when the plaintiff might be released, the public interest in its limited disclosure outweighed its interest in guaranteeing respect for the plaintiff's confidence.²⁷⁷

Egdell's case shows the court engaging in a fact-specific balancing exercise which presumably mental health decision-makers are also expected to perform when assessing patients' risks for the purposes of the compulsory powers.²⁷⁸ In the Scottish case B v Scottish Ministers, the Court of Session stressed that the notion of necessity for the protection of the public under the Scots MHA is 'imprecise and protean'. For that reason, 'whether a particular measure is necessary involves... an appreciation of the measure. The more restrictive [it is] for the liberty of the person concerned, the more one has to test or weigh its necessity'.²⁷⁹ Here too we see the courts preferring a balancing exercise rather than having to deal in absolutes. Decision-makers must therefore ensure that their decision to admit a patient to hospital is *proportionate* to the risks. The only way to achieve this is for the law to play a passive role, abandoning the pretence that there is a universal calculus of risk and instead allowing decision-makers to strike the balance. There are times when the courts cannot rely on rigid principles to decide cases and therefore have to take their cue from the facts.²⁸⁰ The 'evidential problem' that we have discussed may actually give decision-makers leeway to conduct careful balancing exercises and therefore ensure that their deployment of the compulsory powers is proportionate. Yet, while this seems a

²⁷⁷ See also the Californian case Tarasoff v Regents of University of California 551 P.2d 334 (1967).

²⁷⁸ See also R (on the application of Stevens) v Plymouth City Council [2002] EWCA Civ 388, where the Court of Appeal affirmed the importance of striking a balance between competing interests.

²⁷⁹ B v Scottish Ministers, *supra* n.182 at para.26.

²⁸⁰ The cases of Bolton v Stone [1951] AC 850, HL and Miller v Jackson [1977] QB 966, CA are perhaps the best known examples of the courts balancing competing interests to determine whether the respective defendants failed to attenuate the risks of injury, loss or damage in accordance with their duty to the claimants.

practical solution, it means that no two patients with the same mental disorder are likely to share the same experience. Without an understanding of *what* will amount to a risk, the case law suggests that the MHA can never truly achieve legal certainty.

5. The Consequences of Uncertainty: Risk as a Strategic Device?

With no agreed definition and minimal judicial supervision of mental health decision-making, it is submitted that the concept of risk hands practitioners using the MHA a tactical advantage. As soon as they describe a patient in terms of risk, decision-makers legitimise the deployment of the compulsory powers. As we have seen, there are few limits on decision-makers' discretion in this regard and the courts display a high degree of deference to professional opinion. In this way, the concept of risk makes practitioners' jobs easier by essentially bypassing legal supervision. The MHA's risk formula therefore does not put limits on decision-makers' power but is instead facilitative, giving practitioners a freer hand to determine how and where their patients should receive care and treatment. Consequently, risk reduces the significance of the law in mental health practice and leaves the door open for 'strategic decision-making',²⁸¹ wherein a practitioner makes nominal references to risk in order to put into effect an outcome he wishes to achieve, notwithstanding a lack of objective evidence to support such a result. Used thus, risk sanitises decision-making that may be tainted by procedural defects or lacking an adequate evidential basis. It also implicitly legitimises psychiatric 'abuse', undermining psychiatry's principal function as a critical medical specialty 'whose goal is the betterment and welfare of humanity'.²⁸² This is

²⁸¹ See Glover-Thomas, *supra* n.138.

²⁸² A.M. Freedman and A.L. Halpern, 'Psychiatric Abuse in North America' in R. Rosner (ed.) *Principles and Practice of Forensic Psychiatry* 2nd ed., New York: Arnold, 2003, at p742.

not to say that decision-makers acting this way do so for cynical reasons; they are more likely to be motivated by entirely good intentions but use abusive means to justify the ends. Most of all, it shows that practitioners can operate with scant regard for the law.

If the MHA is being used in a tactical way, this would be entirely consistent with the theory of New Medicalism. It would reflect the fact that mental health practice is less about achieving positive health outcomes and more about the management of risk. To what extent does the case law show that risk is used in this way?

5.1. The Courts' Antipathy to the Creative Use of the MHA

The courts have generally taken a dim view of tactical interpretations of the MHA. A mental health decision-maker acts tactically when he uses the MHA to achieve an end that is not expressly authorised by the legislation. The best example of this is R v Hallstrom and Another, ex parte W.²⁸³ Here, W's doctors admitted her to hospital for treatment under section 3 and released her the following day under the leave of absence provisions in section 17. W had been living in a hostel and was refusing to take her medication. Because she was admitted under section 3 and immediately granted leave of absence, W was liable to be detained for the purposes of sections 56 to 64 and therefore her clinical team could override her refusal to consent to treatment. W sought judicial review of the clinical team's decision, contending that her doctors had really wanted to extend their power to overrule her refusal to consent and had deployed section 3 as a means to that end. McCullough J granted a declaration which stated that section 3 could apply only in accordance with the wording of the statute or not at all. His Lordship said that the concept of 'admission for

²⁸³ [1986] QB 1090.

treatment’ has no application ‘to those whom [doctors intend] to admit and detain for a purely nominal period, during which no necessary treatment will be given’.²⁸⁴ The court therefore rejected the tactical deployment of section 3, even though the clinical team had an apparently genuine desire to act in the interests of its patient. A similar strategic gambit was attempted by doctors in R v Wilson, ex parte Williamson,²⁸⁵ this time in respect of section 2. Here, the 28-day period of the patient’s admission for assessment was about to expire and the decision-makers wanted to detain him under section 3. However, his nearest relative refused to support the clinical team’s decision to use section 3, meaning that it would have to release the patient at the end of the 28-day period. Consequently, the decision-makers applied again under section 2 in order to extend the detention period and thus buy more time to displace the patient’s nearest relative. They opted for this instead of applying to the court under section 29 to appoint a new nearest relative, which would have had the effect of extending the patient’s detention until the application’s disposal.²⁸⁶ The court held that section 2 could not be used as a stop-gap procedure or to extend the clinical team’s powers; its sole purpose is limited to providing a legal basis for the compulsory assessment of a person with mental disorder. Hallström and Ex parte Williamson show that the courts will not allow mental health practitioners to make ‘creative’ use of the MHA. This is so even where decision-makers bend the wording of the MHA for the best motives. In GD

²⁸⁴ *Ibid*, per McCullough J at 1105. See also R (on the application of DR) v Mersey Care NHS Trust [2002] EWHC 1810 (Admin), where it was held that a patient’s period of leave could be extended under the MHA 1983 provided that a ‘significant component’ of his interaction with his clinical team took place in a hospital setting.

²⁸⁵ *Independent*, 19 April 1995, QB.

²⁸⁶ MHA, s.29(4)(a).

v The Hospital Managers of the Edgware Community Hospital,²⁸⁷ the patient's clinical team did not consult with his nearest relative in accordance with section 11(4) until the very last moment. The team feared that the patient's nearest relative had not acted in his best interests in the past and sought to proceed without a consultation. Burnett J held that this course of action had seriously inhibited the chances of the nearest relative having any effective input in the patient's care and treatment. As a result, the clinical team's actions amounted to a misuse of power which affected the entire application process. His Lordship said that it was irrelevant that the team had acted 'for the best motives';²⁸⁸ Parliament clearly intended that the nearest relative play a practical role and it was not open to the decision-makers to undermine his participation in the process.

The same rule against the tactical use of the MHA applies at the other end of the compulsory care and treatment process. In R (on the application of Von Brandenburg) v East London and the City Mental Health NHS Trust,²⁸⁹ the claimant had been initially admitted to hospital under sections 4 and 2. He applied to the MHRT under section 66(1)(a) for discharge, which was subsequently granted under section 72. After the tribunal's ruling – but a day before the patient's release from hospital – a social worker applied with the support of two doctors under section 3 to admit the patient to hospital for treatment. The claimant applied for judicial review. The House of Lords held that a social worker could not apply for a patient's admission to hospital under the MHA solely because he had disagreed with the decision of the MHRT. The only basis on which a social worker could reapply for the

²⁸⁷ [2008] EWHC 3572 (Admin).

²⁸⁸ *Ibid*, per Burnett J at para.51.

²⁸⁹ [2004] AC 280, HL.

patient's admission to hospital is where he reasonably and in good faith considers that he has information that was unknown to the tribunal which would put a significantly different complexion on the case. Lord Bingham explained that the MHRT's power of discharge under Part V of the MHA 'would plainly be stultified if proper effect were not given to tribunal decisions for what they decide... [because of] those making application for the admission of a patient under the Act'.²⁹⁰ It is clear that the courts will interpret the MHA literally and will not allow mental health practitioners to distort the legislation as a strategic ruse which runs counter to the letter and spirit of the statute. Indeed, this rule works both ways: in R (on the application of O) v Mental Health Review Tribunal,²⁹¹ the High Court said that an MHRT can refuse to allow an applicant to withdraw his application for discharge if this action appears to be a tactical ploy. Here, the court was concerned that patients could withdraw their applications for discharge in anticipation of an unfavourable ruling from the MHRT and then reapply with a view to being heard by a more sympathetic panel.

Yet, it is important not to regard the courts' antipathy towards the tactical use of the MHA as a symptom of judicial obstruction of mental health practice generally. The courts have drawn a distinction, albeit a fine one, between broad interpretations of the MHA, which are legitimate, and tactical decision-making, which is not. In part 4.2.1, we saw how Lady Hale interpreted section 63 MHA in such a way as to allow doctors to administer medical treatment without the patient's consent in R (on the application of B) v Ashworth Hospital Authority, notwithstanding procedural irregularities in his initial admission. A

²⁹⁰ *Ibid*, per Lord Bingham, at para.8.

²⁹¹ [2006] EWHC 2659.

similar approach can be found in Tameside and Glossop Acute Services Trust v CH²⁹² and B v Croydon Health Authority,²⁹³ where the courts interpreted 'medical treatment' broadly in order to bring a Caesarean section and feeding by means of a naso-gastric tube within the ambit of the MHA respectively. While the objectives sought in these cases were arguably also achieved tactically, they neither entailed a stretching of the wording of the MHA nor an ulterior motive by decision-makers. It seems that the courts are happy to allow mental health practitioners to be flexible in their interpretations of parts of the MHA, provided they do so in good faith.

5.2. Risk Exceptionalism?

Risk's lack of definition, its status as a matter of fact, and the courts' reluctance to review practitioners' decisions culminate in what one might call 'risk exceptionalism' in mental health law. The concept is an exception to the normal procedural rules and it effectively circumvents the oversight of the law. Nowhere is this clearer than in the case law of the ECtHR. According to Article 5(1) of the Convention, everyone has the right to liberty and security of the person. This is qualified by Article 5(1)(e), which states that no one shall be deprived of his liberty *unless* he is a person of unsound mind and he is detained in accordance with a procedure prescribed by law. The ECHR thus recognises that a State Party can use mental illness as a ground for suspending a person's liberty. In Winterwerp v The Netherlands,²⁹⁴ the ECtHR said that the term 'unsound mind' in Article 5(1)(e) was not capable of having a definitive interpretation; its meaning evolves constantly in light of

²⁹² [1996] 1 FCR 753.

²⁹³ [1995] Fam 133.

²⁹⁴ ECtHR, Application No. 6301/73, Judgment of 24 October 1979.

psychiatric research, new treatments and changes in society's attitude to mental illness.²⁹⁵

For that reason, the Court recognised that the relevant national authorities of State Parties have discretion to decide whether an individual should be detained as a 'person of unsound mind'.²⁹⁶ In this way, the Court divested itself of the responsibility of specifying *what* would amount to 'unsound mind' for the purposes of Article 5(1)(e). However, it did set out procedural requirements with which each State Party to the Convention should comply. First, a patient must be reliably shown to the relevant national authority to be of 'unsound mind', which calls for objective medical expertise. Secondly, his mental disorder must be of a kind or degree that warrants compulsory confinement. Thirdly, the person's detention must persist only as long as his disorder does.²⁹⁷ Provided that a State Party incorporates these requirements into its legal framework and that its competent national authority applies them, then it will comply with Article 5(1)(e) of the ECHR.

Subsequent cases have affirmed Winterwerp and have also made additional observations about the meaning of 'a procedure prescribed by law'. In Varbanov v Bulgaria,²⁹⁸ the Court said that a necessary element of the 'lawfulness' of detention is the absence of arbitrariness. This means that all decisions to admit patients to hospital on a compulsory basis should be taken in accordance with the opinion of a medical expert.²⁹⁹ It

²⁹⁵ *Ibid*, para.37.

²⁹⁶ *Ibid*, para.40 .

²⁹⁷ *Ibid*, para.39.

²⁹⁸ ECtHR, Application No. 31365/96, Judgment of 5 October 2000.

²⁹⁹ *Ibid*, paras.46-7.

also means that those experts must not be motivated by bad faith or deception.³⁰⁰ In Sabeva v Bulgaria,³⁰¹ the Court said the requirement in Article 5(1) that a procedure to suspend a person's liberty be lawful also means that the law 'should be accessible to the persons concerned and foreseeable as to its effects'.³⁰² It is clear that the Convention jurisprudence expects that the domestic law of States Parties will be procedurally rigorous and legally certain.³⁰³

It is difficult to deny that the MHA's grounds for compulsory admission mirror the Winterwerp criteria. It is also true that domestic courts have read slight modifications into the MHA's mechanics in order to align the legislation closely with the standards expected by the Convention.³⁰⁴ Having said this, Winterwerp does not refer explicitly to risk as a prerequisite for the suspension of a patient's liberty; it was only later that the ECtHR recognised that the interests of the patient's health or safety and the protection of other people constitute the rationale for compulsory care and treatment.³⁰⁵ It is not clear

³⁰⁰ X v Finland ECtHR, Application No. 34806/04, Judgment of 3 July 2012, at para.147; Saadi v United Kingdom ECtHR Application No. 13229/03, Judgment of 29 January 2008, at paras.68-9.

³⁰¹ ECtHR, Application No. 44290/07, Judgment of 10 June 2010.

³⁰² *Ibid*, para.57.

³⁰³ The ECtHR's emphasis on legal certainty is not just limited to mental health cases: see, e.g., the criminal case of Kokkinakis v Greece ECtHR, Application No. 14307/88, Judgment of 25 May 1993.

³⁰⁴ See, e.g., R (on the application of C) v London South and South West Region Mental Health Review Tribunal [2002] 2 FCR 181 R (on the application of H) v Secretary of State for the Home Department [2003] UKHL 59; R (on the application of MH) v Secretary of State for Health [2005] UKHL 60.

³⁰⁵ See, e.g., Guzzardi v Italy ECtHR, Application No. 7367/76, Judgment of 6 November 1980, at para.98: '*The reason why the Convention allows [persons of unsound mind]... whom are socially maladjusted to be deprived of their liberty is not that they have to be considered as occasionally dangerous for public safety but also that their own interests may necessitate their detention.*' See also Witold Litwa v Poland ECtHR, Application No. 26629/95, Judgment of 4 April 2000, at para.60; Gorshkov v Ukraine ECtHR, Application No. 67531/01, Judgment of 8 November 2005.

therefore whether the ECtHR expects a variation on the MHA's risk formula to serve as another admission criterion in the domestic laws of States Parties. It seems that considerations of patients' risks may be a handy added extra as far as the Convention is concerned. In Reid v United Kingdom,³⁰⁶ the applicant had been detained in hospital solely on the basis of a diagnosis of anti-social personality and psychopathic disorder. Following the introduction of the Mental Health (Scotland) Act 1984, patients with the applicant's condition could only be detained in hospital for treatment where their mental disorder satisfied a treatability test.³⁰⁷ The applicant relied on medical evidence to argue that his mental disorder was not treatable, whereas the Sheriff refused to order his release because there was a risk that Reid would display violent and sexualised behaviour. The applicant contended that the United Kingdom had violated his right to liberty under Article 5(1) ECHR by keeping him detained in hospital when his condition was no longer treatable for the purposes of the 1984 Act. The ECtHR held that there had been no violation of the applicant's rights under Article 5(1): the Convention jurisprudence did not recognise the concept of treatability; all that matters is that the patient has a mental disorder of a degree warranting confinement.³⁰⁸ For the purposes of the Convention, there could be no breach of Article 5(1) where a person is diagnosed with a mental disorder but is detained in breach of some esoteric provision of domestic law. It is quite legitimate to confine someone on the basis that he needs control and supervision to prevent him causing harm to himself or others; i.e., in response to the risks.³⁰⁹ It is here that we encounter a paradox: while the ECtHR regards

³⁰⁶ (2003) 37 EHRR 9.

³⁰⁷ See, Mental Health (Scotland) Act 1984, s.17(1)(a)(i).

³⁰⁸ Reid's case, *supra* n.306, at para.51.

³⁰⁹ *Ibid.*

legal certainty as critically important to upholding the Convention rights, it is apparently happy to sanction decisions to deprive patients of their liberty on the basis of subjective assessments of risk that may generate the antithesis of certainty. It is difficult to see how risk, with its definition and evidential problems, can possibly create a legal basis for detention that is not arbitrary, is accessible to the patient and foreseeable in its effects. Surely this runs directly contrary to the Convention's standards?

Crucially, the ECtHR, like domestic courts, prefers not to interfere in matters it believes are beyond its competence. As long as a State Party's domestic mental health legislative framework complies with Winterwerp *as a minimum*, there will be no breach of Article 5(1) ECHR. This means that issues arising out of the risk formula are of no concern for the ECtHR. This in turn means that 'risk talk' completely bypasses the Convention's protections, handing decision-makers a tactical advantage to achieve their desired outcomes without contravening human rights provisions. This point is helpfully demonstrated by X v United Kingdom,³¹⁰ where the ECtHR said that whilst it had the jurisdiction to verify the fulfilment of the Winterwerp criteria, 'the logic of the system of safeguards established by the Convention places limits on the scope of this control', meaning that national authorities are better placed to evaluate the evidence adduced before them.³¹¹ In X, the Home Secretary, on the advice of X's medical officer, ordered that the applicant be recalled to hospital when his mental health deteriorated following his conditional discharge from a secure unit. The medical officer had not examined the patient; he referred the matter to the Home Office urgently on the strength of the applicant's history of impulsive and dangerous conduct and

³¹⁰ ECtHR, Application No. 7215/75, Judgment of 5 November 1981.

³¹¹ *Ibid*, para.43.

reports of his presumed deterioration alone. The applicant argued that his recall breached Article 5(1) because he had not been ‘reliably’ shown to be of unsound mind by objective medical evidence. The ECtHR disagreed, holding that the merits of a decision to recall a patient to hospital are a matter for the national authority. We can infer from the X case that what amounts to a risk for the purposes of the MHA is a matter for the decision-maker(s). Even where that decision-maker may have labelled the patient a risk on the basis of weak or unconvincing evidence, it seems that because the MHA complies generally with the Winterwerp criteria there will be no violation of Article 5(1). In this way risk’s exceptionalism takes practitioner’s decisions beyond the scrutiny of the ECtHR. This is illustrated by *figure 3.3* below:

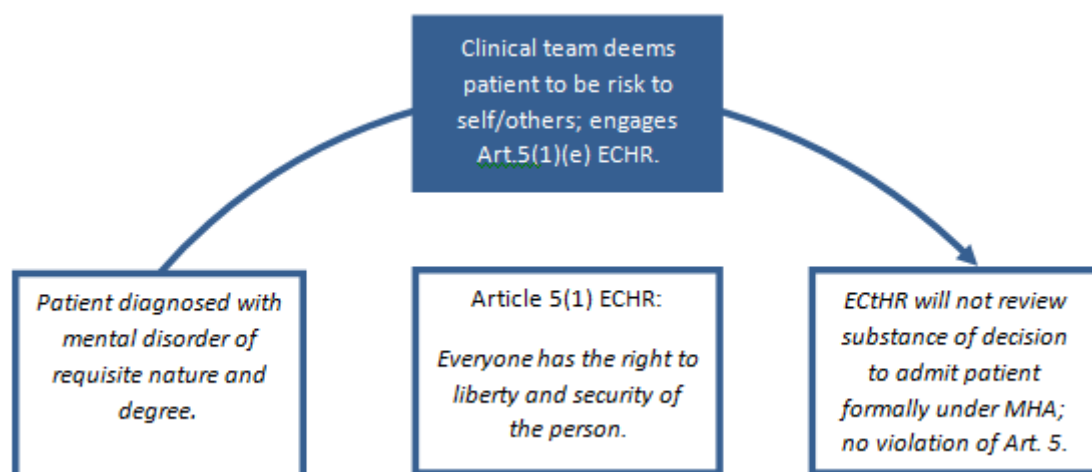


Figure 3.3. Diagram illustrating how the concept of risk bypasses the protections of the ECHR in decision-making under the MHA.

It is submitted that domestic courts have followed the same pattern exhibited by *figure 3.3*, *mutatis mutandis* in relation to the MHA’s risk formula more broadly. Once a patient is described in terms of risk, the courts effectively disavow any power to review the basis of mental health professionals’ decisions. In this way, discussions of risk bypass the protections of the law and reduce its capacity to restrict decision-makers’ discretion. At the same time,

risk allows practitioners to achieve the outcomes they desire. It is clear that risk truly is exceptional: while the law demands certainty and consistency on one hand, it incorporates a concept whose practical effects are anathema to these ideals on the other.

6. Conclusions

The problem with risk is that it is not clear what it means. Colloquially, it may be easy to infer its meaning from context. Even where it is employed formally, the concept is likely to have a technical application. Generally, however, risk is a multi-faceted concept with a wide semantic range. The only universal characteristics it possesses are negativity and contingency. In all other respects, 'risk' is capable of meaning many things to different people.

Risk is also pivotal to the MHA. It is the gateway to the compulsory powers and is the 'golden thread' that runs through the legislation. If a clinical team concludes that it is necessary to admit a patient to hospital for treatment in the interests his health or safety or for the protection of other people, this fundamentally changes the complexion of that patient's engagement with mental health services. He can be detained in hospital for up to six months at a time. He can face restrictions on his interactions with the outside world. He can receive medical treatment without regard to his capacity to consent. The entire mechanics of the MHA constitute a scheme for the assessment and monitoring of patients' risks. One might assume that it behoves the law to specify a clear legal basis on which such treatment must be authorised.

In fact, it does no such thing. The MHA neither defines 'risk' nor delimits the factors that might be probative of it. The Code of Practice and other extra-legal guidance are open-

ended and non-exhaustive. The courts too have contributed to the confusion: 'risk' is not a term of art; it must be given its natural and ordinary meaning (whatever that is); it is divisible and modifiable (even where the MHA recognises no such trait). While the courts have offered some guidance, they are keen not to interfere in the mental health professionals' domain. Consequently, the evidential threshold and standard of proof are low; decision-makers must balance the interests of the patient in his liberty with those of the wider public. When it comes to risk, within reason, anything practitioners recast as evidence of a threat to the patient's health or safety or to others is enough to justify the deployment of the compulsory powers.

The consequence of this problem with risk is that it undermines legal certainty. For all the courts' insistence on the law's foreseeable effects and predictability, they tolerate a concept that undermines these virtues in the MHA. The effect of this is to reduce the law from a bulwark against arbitrary clinical power to a passive facilitator of it. Risk hands decision-makers an important tactical advantage which allows them to achieve their desired outcomes legitimately. The question whether this occurs cynically or not misses the point: the MHA incorporates a concept into its compulsory care and treatment regime which has the effect of neutralising the law's ability to defend patients' interests. It is surely contrary the purpose of a statutory regime if it legitimises the bypassing of its own protections. In light of the 2007 Act, the question is whether this has led to greater infringements of the liberty of people with mental disorder.

Part Two

Jeopardising Liberty, Facilitating Control?

Chapter 4

The Post-2007 Act Era: More Control, Less Liberty?

1. Introductory

So far we have established three things. First, risk was the principal policy driver of the Mental Health Act 2007 ('2007 Act'). Secondly, constructions of risk in social theory can illuminate the reasons for the prominence given to risk in mental health law and policy. Thirdly, risk is a problematic concept from a legal point of view. These three points allow us to hypothesise that the post-2007 Act era will be characterised by uncertainty. In this chapter, we put this hypothesis to the test.

This is perhaps the most important chapter in the thesis. It seeks to bring together the policy, theoretical and legal analyses from the previous chapters by examining the impact of the 2007 Act on mental health decision-making. It will ask whether the anticipated effects of its reforms have become a reality. While it might be reasonable to assume that New Medicalism has led to an increase in the number of people admitted to hospital under the compulsory powers and a concomitant decline in the law's determinative power, this chapter will show that the post-2007 Act era may not have turned out in this way. First, we examine hospital admission statistics from the four years since the 2007 Act's amendments came into force. We will see that these data reveal an increase in the number of people

admitted to hospital on a compulsory basis since 2008.¹ However, we will also see that there is little evidence of a causal link between the 2007 Act and this increase.

This raises two important questions which this chapter will then interrogate: (i) do reforms to mental health laws always achieve their policy objectives, and (ii) does mental health law actually map decision-making practice? The first question requires some consideration of mental health law and policy at the macro level. To answer it, this chapter will draw upon literature from North America from the 1970s and 1980s, during which time there was radical upheaval in local mental health laws. The second question examines the impact of mental health law at the micro level. Here, we consider the empirical evidence which relates to the role that mental health law plays (or does not play) in influencing practitioners' decision-making. This chapter will then conclude by answering the question that forms the title of the chapter: is the post-2007 Act era really defined by more control and less liberty?

In the four years since the 2007 Act came into force there have been few studies of its impact. It is perhaps too soon to expect an expansive literature which compares the workings of the original MHA 1983 with its recently amended version. The debate has also moved on since 2007.² This chapter therefore draws on pre-existing evidence and extrapolates from that the *likely* impact of the 2007 Act. The aim here is to identify whether

¹ The 2007 Act received Royal Assent on 19th July 2007 but many of its amendments did not come into force until 3rd November 2008, meaning that at the time of writing the amended MHA has been at large for four years. On the commencement provisions, see s.56 of the 2007 Act and the Mental Health Act 2007 (Commencement No.7 and Transitional Provisions) Order 2008, SI 2008/1900, Article 2.

² See, e.g., P. Bartlett, 'The United Nations Convention on the Rights of Persons with Disabilities and the Future of Mental Health Law' (2009) 8(12) *Psychiatry* 496; P.D. Bartlett, 'The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law' (2012) 75(5) *The Modern Law Review* 752.

the early evidence of the impact of the 2007 Act is consistent with longer-term trends. It is hoped that this chapter will signpost the need for future studies.

2. The Impact of the 2007 Act

The 2007 Act removes many of the obstacles to compulsory care and treatment that characterised the 1983 Act. In chapter one, we saw how policy-makers justified the simpler definition of ‘mental disorder’,³ the abolition of the ‘treatability’ test,⁴ supervised community treatment (SCT),⁵ and the changes to the roles of mental health professionals⁶ as measures necessary to ensure that the amended MHA was more responsive to patients’ risks and less encumbered by legalistic restrictions. Prior to the 2007 Act, the received wisdom stated that if changes to mental health law were to *lower* the threshold for compulsory intervention in this way they would *increase* the total number of patients subject to compulsory care and treatment.⁷ Commenting on the Mental Health Bill in 2006, Brown endorsed this view and contended that were its provisions to become law they ‘would make possible the sectioning of a much wider number of potentially dangerous, though not “mentally ill”, individuals.’⁸ Since the 2007 Act came into force, Fennell has

³ MHA, s.1(2), as amended by 2007 Act, s.1(2). ‘Mental disorder’ means ‘any disorder or disability of the mind’.

⁴ The ‘treatability’ test under MHA, s.3(2)(b) was repealed by the 2007 Act. A new ‘appropriate treatment’ test was inserted at MHA, s.3(2)(d) by s.4 of the 2007 Act.

⁵ MHA, ss.17A-17G; 19A; 20A-20B; and Part IVA.

⁶ 2007 Act, ss.9-17.

⁷ See, e.g., E. Munro and J. Rumgay, ‘Role of Risk Assessment in Reducing Homicides by People with Mental Illness’ (2000) 176 *British Journal of Psychiatry* 116, at p119.

⁸ P. Brown, ‘Risk versus Need in Revising the 1983 Mental Health Act: Conflicting Claims, Muddled Policy’ (2006) 8(4) *Health, Risk and Society* 343, at p355.

argued that its amendments have removed from decision-makers the discretion *not* to use the compulsory powers.⁹ There is now a presumption that a patient with a mental disorder of the requisite nature or degree should be compulsorily admitted to hospital. To what extent have the reforms had the impact that was anticipated?

2.1. The Statistical Evidence

2.1.1. After the 2007 Act: More Admissions, Less Informality

The number of people detained in hospital under the MHA has increased since 2008. In the year before the 2007 Act came into force, there were 44,093 detentions under the MHA,¹⁰ of which 27,234 were formal admissions and 14,839 were detentions subsequent to voluntary or informal admission.¹¹ The year after there were 44,543 detentions under the MHA across both NHS and private mental health units, 27,946 of which comprised formal admissions and 14,701 were detentions subsequent to admission.¹² This represented a 1 *per cent* increase in the total number of detentions, a 2.6 *per cent* increase in the number of formal admissions and a 0.9 *per cent* fall in the number of detentions following informal admission in the 2007 Act's first year of operation. While there was indeed a slight increase in the number of formal admissions, it cannot be described as significant. Any expectation

⁹ P. Fennell, *Mental Health: Law and Practice*, 2nd ed., Bristol: Jordans Publishing Limited, 2011, at p90.

¹⁰ National Health Service Information Centre for Health and Social Care and the Office of National Statistics, *In-patients Formally Detained in Hospitals under the Mental Health Act 1983 and Patients Subject to Supervised Community Treatment: Annual Figures, England 2011/12*, 24 October 2012. Available at: <http://www.ic.nhs.uk/pubs/inpatientdetmha1112>. Accessed: 27 October 2012. Hereafter, 'In-patient statistics 2011/12'.

¹¹ 'Detentions subsequent to admission' applies to situations in which a patient with mental disorder is formally detained under the MHA after he arrives at hospital, e.g., by virtue of the police power to remove a mentally disordered person found in public place to a place of safety under s.136.

¹² In-patients statistics 2011/12, *supra* n.10.

that the amended MHA would have an immediate and significant effect on the number of compulsory admissions was therefore misconceived.

The increase in the rate of admissions is noticeable, however, in more recent statistics. According to data from 2011-12 there were 48,631 detentions that year - 30,900 of which were formal admissions and 13,680 were detentions subsequent to informal admission.¹³ Compared to the data from 2008-09, there was a 9 *per cent* increase in the number of detentions, a 10 *per cent* increase in the number of formal admissions and a cut of 8 *per cent* in the number of detentions subsequent to admission. When we examine these medium term statistics, it appears that since the 2007 Act's amendments took effect there has been a significant change in the annual number of admissions. On this measure those who expected a correlation between the broader commitment criteria and increases in the number of admissions to hospital were quite astute. Even the decline in the number of detentions subsequent to admission does not necessarily contradict their analysis; these statistics include the *informal* equivalents of sections 2 and 3 MHA, whose use has declined by 3 *per cent* and 22 *per cent* respectively since 2007/08.¹⁴ This decline undoubtedly owes something to the introduction of the Deprivation of Liberty Safeguards ('DOLS'), which have in many ways 'formalised' the procedure of caring for informal patients and thereby created an alternative mechanism to the compulsory powers. Alternatively, it may be that decision-makers are now less willing to attempt informal care and treatment before resorting to compulsion. In any event, the data support Fennell's view that the 2007 Act has removed decision-makers' discretion *not* to deploy the compulsory powers; it seems mental health

¹³ *Ibid.*

¹⁴ *Ibid.*

professionals are now less inclined for whatever reason to try voluntary or informal engagements with patients. This is evidence that the 2007 Act may have recalibrated the priorities of decision-makers. In *figure 4.1*, we can see that in the four years since the introduction of the 2007 Act, there has been an increase in the number of compulsory admissions each year. Only the data from 2010/11 appear to be the outliers here. On one hand, this may reflect the impact of the DOLS regime on the statistics in its first full year of operation; on the other, it may be that the data from 2010/11 merely represent an anomaly – this seems particularly plausible when one considers that the figures for 2011/12 restore the trend to its previous trajectory.

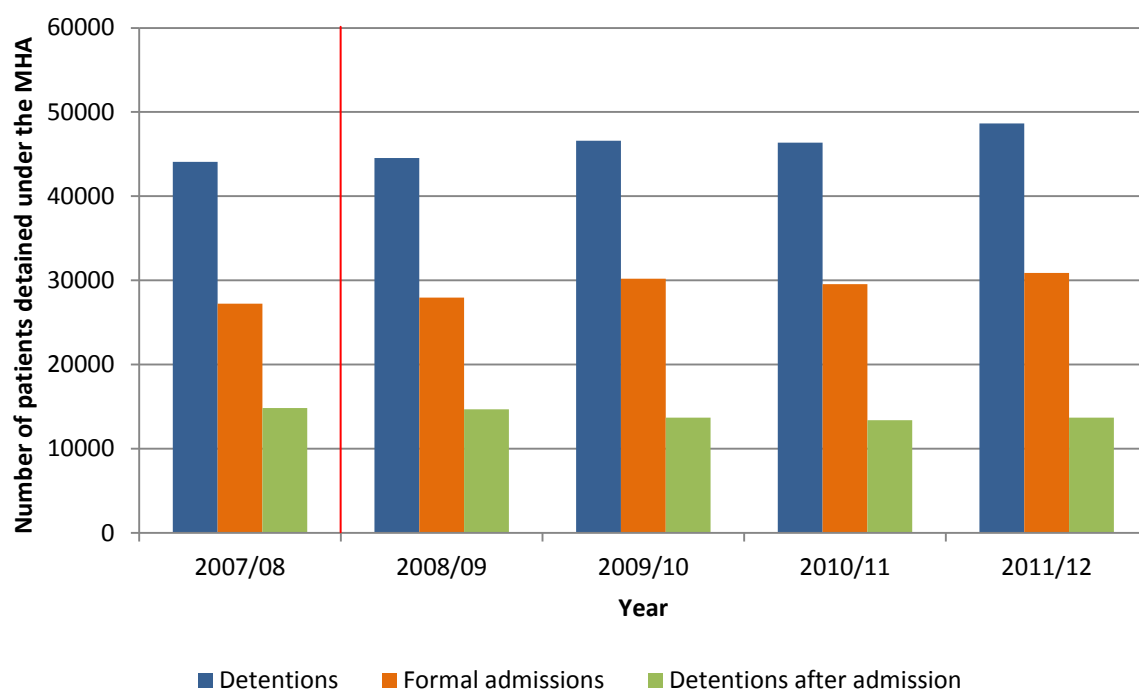


Figure 4.1. A bar chart showing the number of detentions, formal admissions and detentions after admission one year prior to and four years after the 2007 Act's amendments came into force. The red line denotes when the reforms came into effect.

While *figure 4.1* exhibits the increasing use of the compulsory powers since the 2007 Act was passed, *figure 4.2* reveals the concomitant decline in the number of informal admissions which were transferred into formal commitments over the same period. We can

infer that mental health practitioners are increasingly erring on the side of formal admission instead of relying on the flexibility of informal arrangements. This may be the reason why detentions *after* admission have declined since 2008.¹⁵

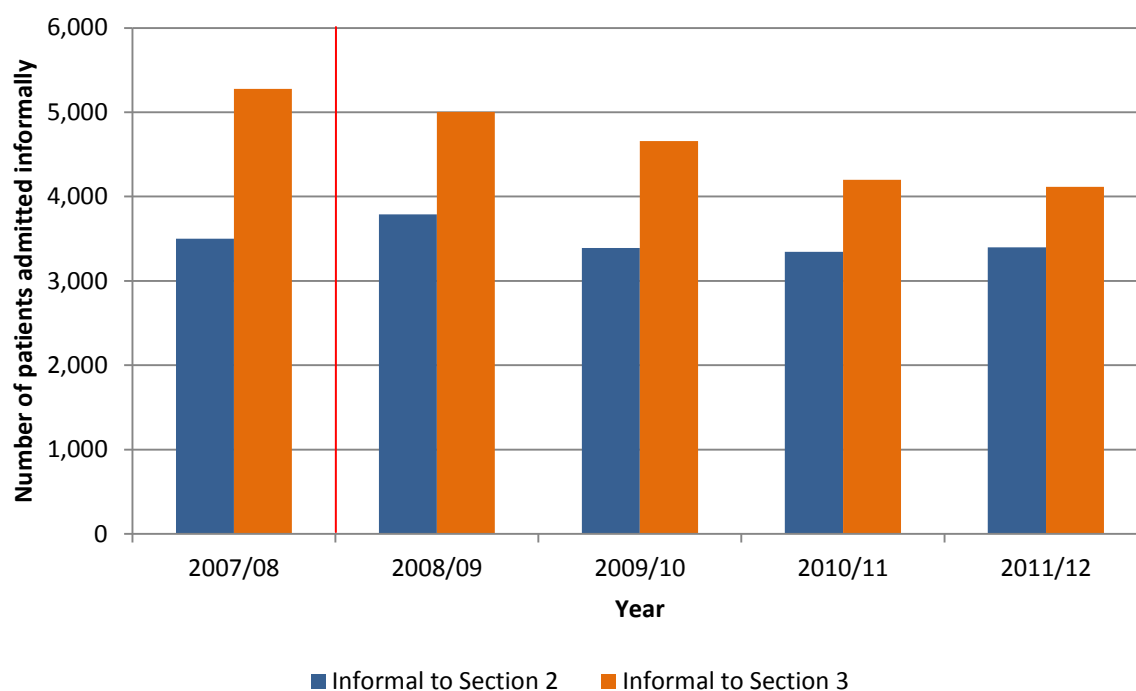


Figure 4.2. A bar chart showing the number of informal assessment and treatment arrangements which were transferred into formal admissions under sections 2 and 3 MHA respectively in each reporting year. The red line marks the point at which the 2007 Act's amendments became operational.¹⁶

The NHS Information Centre compiles data on the number of patients detained in hospital on 31st March each year.¹⁷ This offers a useful snapshot of the extent of the deployment of the compulsory powers at a particular moment in time. On 31st March 2005, fully four reporting years before the 2007 Act came into force, there were 14,681 people

¹⁵ In-patients statistics 2011/12, *supra* n.10, at Table 1 in Appendix 1.

¹⁶ In-patients statistics 2011/12, *supra* n.10, at Table 1 in Appendix 1.

¹⁷ See, e.g., In-patients statistics 2011/12, *supra* n.10, at Table 8 in Appendix 1.

detained in hospital under the MHA.¹⁸ On the 31st March 2008, some eight months before the reforms became operational, there were 15,181 patients held in hospital.¹⁹ One year later, the number had increased by 6 *per cent* to 16,073²⁰ and on 31st March 2012 it had leapt to a staggering 17,503.²¹ This means that in the eight reporting years between 2005 and 2012 (inclusive) the number of people detained in hospital under the MHA on 31st March grew by 20 *per cent*. We can see from the bar chart in *figure 4.3* that there was a clear acceleration of this growth after the 2007 Act took effect. It is also apparent that the trend since 2009 has shown a sustained increase in the number of people detained in hospital; prior to the 2007 Act the number fluctuated around the 15,000 mark.

¹⁸ Care Quality Commission, *Monitoring the Use of the Mental Health Act in 2009/10*, (hereafter, 'CQC 09/10') at p21. Available at: http://www.cqc.org.uk/sites/default/files/media/documents/cqc_monitoring_the_use_of_the_mental_health_act_in_200910_main_report_tagged.pdf. Accessed: 12th November 2012.

¹⁹ *Ibid.*

²⁰ Care Quality Commission, *Monitoring the Mental Health Act in 2010/11* (hereafter, 'CQC 10/11'), at p17. Available at: http://www.cqc.org.uk/sites/default/files/media/documents/cqc_mha_report_2011_main_final.pdf. Accessed: 12th November 2012.

²¹ In-patients statistics 2011/12, *supra* n.10, at Table 8 in Appendix 1.

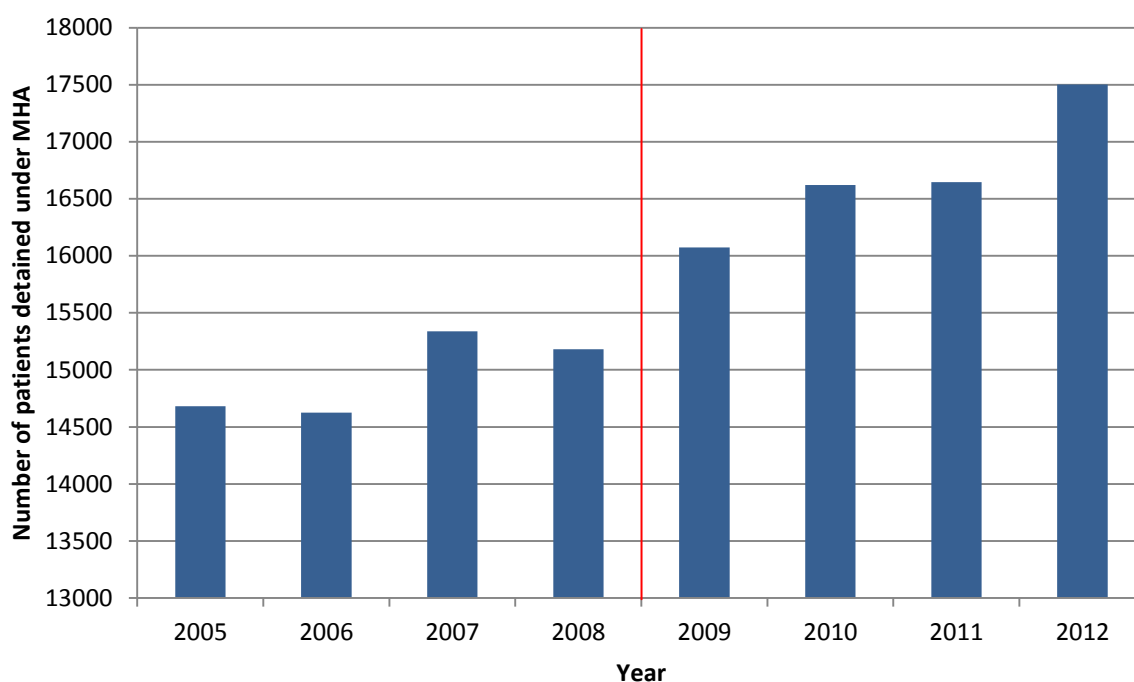


Figure 4.3. A bar chart showing the number of patients detained in hospital under the MHA on 31st March of the reporting year. The red line marks the point at which the 2007 Act's reforms became operational.²²

On some measures the 2007 Act has had a clearly discernible impact which comports with broadening the criteria for compulsory commitment. Since 2008, there has been a steady growth in the number of admissions under the MHA, fewer patients are subject to informal arrangements, and more people are held under the compulsory powers than at any given time in the last eight years. This has led the Care Quality Commission to recommend that policy-makers interrogate the reasons why more people are subject to the MHA and develop appropriate responses.²³ Yet it has not been entirely one-way traffic: the data suggest that the impact of the 2007 Act may in fact be either more complex or, strangely,

²² Data drawn from CQC 09/10, *supra* n.18, and In-patients statistics 2011/12, *supra* n.10.

²³ Care Quality Commission, *Monitoring the Mental Health Act in 2011/12*, at p85. Available at: http://www.cqc.org.uk/sites/default/files/media/documents/cqc_mentalhealth_2011_12_main_fin_al_web.pdf. Accessed: 12 February 2013.

much simpler than analyses like Fennell's suggest. There are two reasons for this, which are worth considering in some detail.

2.1.2. The Decrease in the Number of Admissions for Treatment

First, there has actually been a *decrease* in the number of section 3 admissions for treatment since the 2007 Act was introduced. This has occurred notwithstanding an *increase* in the number of section 2 admissions in the same period. It has also occurred despite the emphasis on risk in the 2007 Act, which one might expect would have led to an increase in the use of the compulsory powers. *Figure 4.4* shows the extent of this divergence by exhibiting the respective contributions admissions under sections 2 and 3 have made to the total number of formal admissions since the 2007 Act was introduced. While the use of section 2 has increased by nearly 30 *per cent* over the last four years, decision-makers' deployment of section 3 has shrunk by a fifth.²⁴

²⁴ There were 9,601 uses of section 3 in 2008/09, compared with just 7,701 in 2011/12. Section 2 was used 16,153 times in 2008/09, rising to 20,931 in 2011/12. See, In-patients statistics 2011/12, *supra* n.10 at Table 1 in Appendix 1.

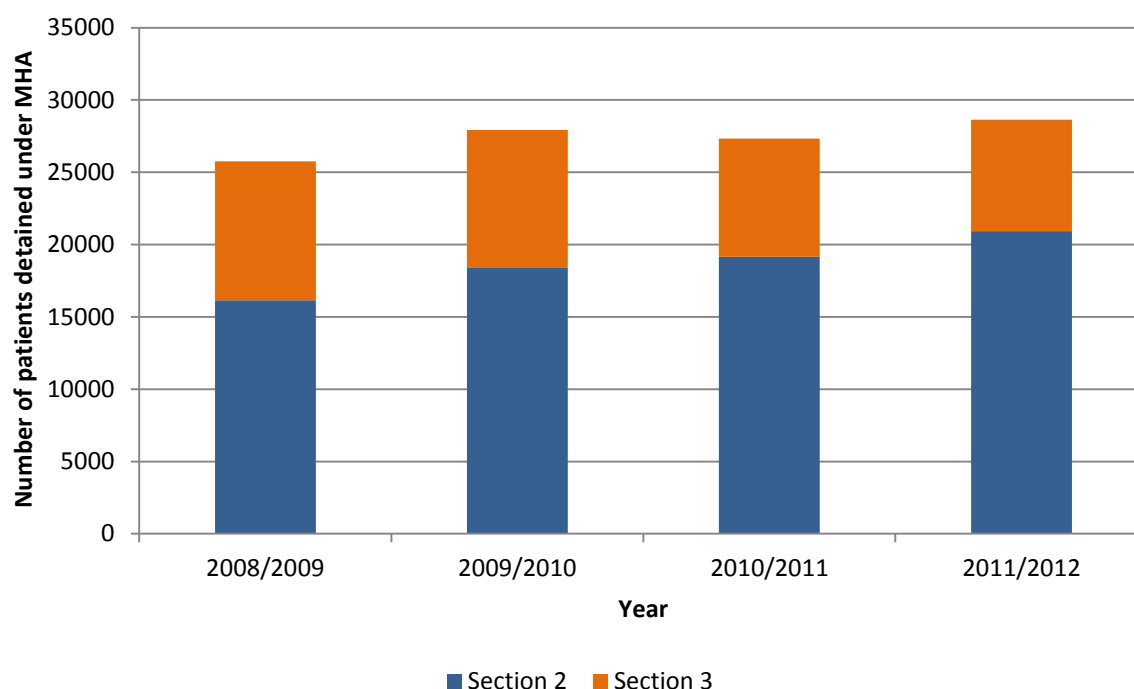


Figure 4.4. A bar chart showing the respective contributions of admissions under sections 2 and 3 MHA to the total number of admissions under the MHA in each reporting year since the 2007 Act's amendments came into effect.²⁵

This trend completely defies expectations: surely if the 2007 Act removes or weakens the legal obstacles to compulsory treatment there should be an increase in the use of section 3 after 2008? Why has that not occurred?

There are three possible reasons. First, decision-makers may have responded to the policy emphasis on risk by making generous use of section 2, which is much less exacting (and therefore easier to engage) than section 3. It may be that this allows decision-makers to give effect to the 2007 Act's policy objectives. The steep decline in the use of section 3 might reflect the fact that fewer patients can be 'upgraded' because their clinical diagnosis or risk profile does not give rise to an adequate legal basis for compulsory treatment. This reason is unconvincing because it assumes that decision-makers operate 'politically' when using section 2 but 'clinically' when using section 3. We know that the purpose of the 2007

²⁵ In-patients statistics 2011/12, *supra* n.10, at Table 1 in Appendix 1.

Act was to lessen the MHA's legalistic prescriptions across the board – so why would the use of admission for assessment increase but the deployment of section 3 decline?

Secondly, and more convincingly, Supervised Community Treatment (SCT) has effectively reduced the demand for section 3 admissions because qualifying patients who at one time would have been detained in hospital for treatment can now be made the subject of a Community Treatment Order (CTO). According to section 17D(1) of the MHA, the application for admission for treatment does not cease to have effect when a patient becomes subject to a CTO. Should he be recalled to hospital or should the clinical team revoke his CTO, then the patient's original admission subsists. This means that a patient whose CTO is revoked is not 're-sectioned' under section 3 and is therefore not counted twice for the purposes of the statistics.²⁶ The NHS Information Centre collects separate data relating to SCT. Since their introduction, CTOs have proved to be popular. In their first year, clinical teams issued 2,109 Orders and by 2011/12 4,086 patients were subject to CTOs – a 93 *per cent* increase over four years.²⁷ Over the same period, the number of recalls and revocations grew nearly tenfold from 206 to 2,045 and 142 to 1,429 respectively. *Figure 4.5* shows how rapidly the SCT regime has grown over the last four years:

²⁶ See, e.g., National Health Service Information Centre for Health and Social Care and the Office of National Statistics, *In-patients Formally Detained in Hospitals under the Mental Health Act 1983 and Patients Subject to Supervised Community Treatment: Annual Figures, England 2010/11*, October 2011, at p12. Available at: http://www.ic.nhs.uk/webfiles/publications/005_Mental_Health/Inpatients%20Mental%20Health%20201011/Inpatients_detained_MHA_2010_11_report_v2.pdf. Accessed: 12th November 2012. See also, In-patients statistics 2011/12, *supra* n.10, at p14.

²⁷ In-patients statistics 2011/12, *supra* n.10, at Table 7a in Appendix 1.

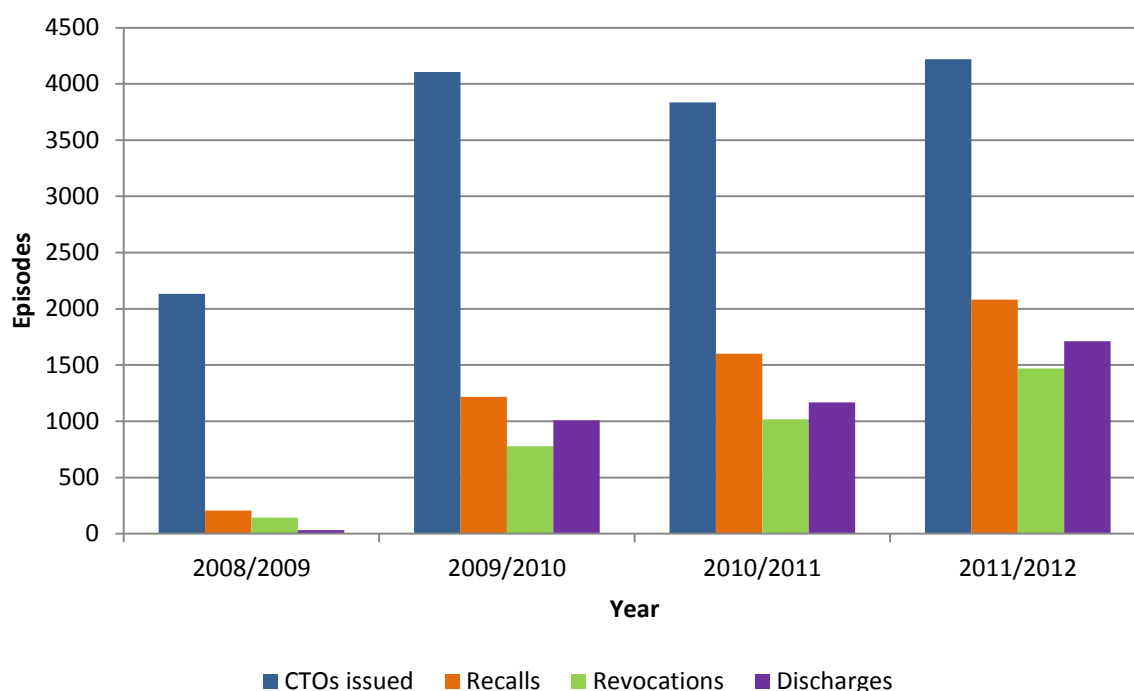


Figure 4.5. A bar chart showing the number of CTOs that were issued and how many recalls, revocations and discharges took place in each reporting year.

The NHS Information Centre believes that this explosion in the use of SCT may explain why there has been a decline in the number of section 3 admissions.²⁸ It is submitted that this is a credible explanation. While this perhaps bucks the trend one might have expected after the 2007 Act, it is still consistent with Fennell's view that decision-makers are now *less* likely to treat patients outside the scope of the MHA. Indeed, it may be that the SCT mechanism has transformed the MHA into a more comprehensive risk management 'regime' of the type that Hood *et al* describe (see chapter two).²⁹ Heilbrun argues that risk management models are particularly sensitive to changes in patients' statuses because (a) the assessments are multiple across time, and (b) they focus on dynamic factors.³⁰ In this way, the assessment of

²⁸ In-patients statistics 2010/11, *supra* n.10 and 2011/12, *supra* n.26.

²⁹ C. Hood, *et al*, *The Government of Risk: Understanding Risk Regulation Regimes*, Oxford: OUP, 2004, at p3.

³⁰ K. Heilbrun, 'Prediction versus Management Models Relevant to Risk Assessment: the Importance of Legal Decision-making Context' (1997) 21(4) *Law and Human Behaviour* 347, at p353.

risk is not a predictive process made prior to the patient's admission but a continuing exercise. If we see SCT as a tool for the management of patients' risks then the rapid growth in the deployment of CTOs is not surprising. When one considers all the available data it becomes clear that the received wisdom may be too simplistic. The 2007 Act shows that the effects of reform in this area can be complex.

A third reason for the apparently counterintuitive decline in the number of admissions for treatment since 2008 may be the impact of the DOLS regime. In chapter three, we saw that the primary aim of the Safeguards was to plug the Bournewood gap and protect informal patients' Convention rights. Before the DOLS became operational, decision-makers had to choose to provide care and treatment either within or without the MHA. Since 2009, they have been able to apply for a standard authorisation to deprive informal patients of their liberty for the purposes of administering this care and treatment *without* recourse to the MHA. Consequently, it would not be surprising if this new way of engaging patients has had an impact on the number of admissions under the MHA. While there is no evidence to suggest that the DOLS regime has directly caused a fall in the number of admissions for treatment under section 3, there is a compelling correlation. In 2009/10 there were 7,157 applications for a standard authorisation in England and Wales, of which 3,297 (or forty-six *per cent*) were granted.³¹ A year later, the number of applications rose to 8,982; of these 4,951 (or fifty-fix *per cent*) were successful.³² While the number of applications and

³¹ Care Quality Commission, *The Operation of the Deprivation of Liberty Safeguards in England, 2009/10*, March 2011, at p6.

³² Care Quality Commission, *The Operation of the Deprivation of Liberty Safeguards in England, 2010/11*, March 2012, at p6.

authorisations comes nowhere near the levels predicted by the Department of Health,³³ a significant number of patients have been taken beyond the reach of the MHA. During the same period there was a fall in both the number of informal admissions converted into compulsory interactions and the number of detentions for treatment. Although it is difficult to prove causation, there may be a link between the introduction of the DOLS regime and the concurrent fall in the use of two key aspects of the MHA. Moreover, if the trend illustrated in *figure 4.6* were to continue, the Safeguards may come to play an even larger part in mental health care and treatment and thereby challenge the dominance of the MHA.

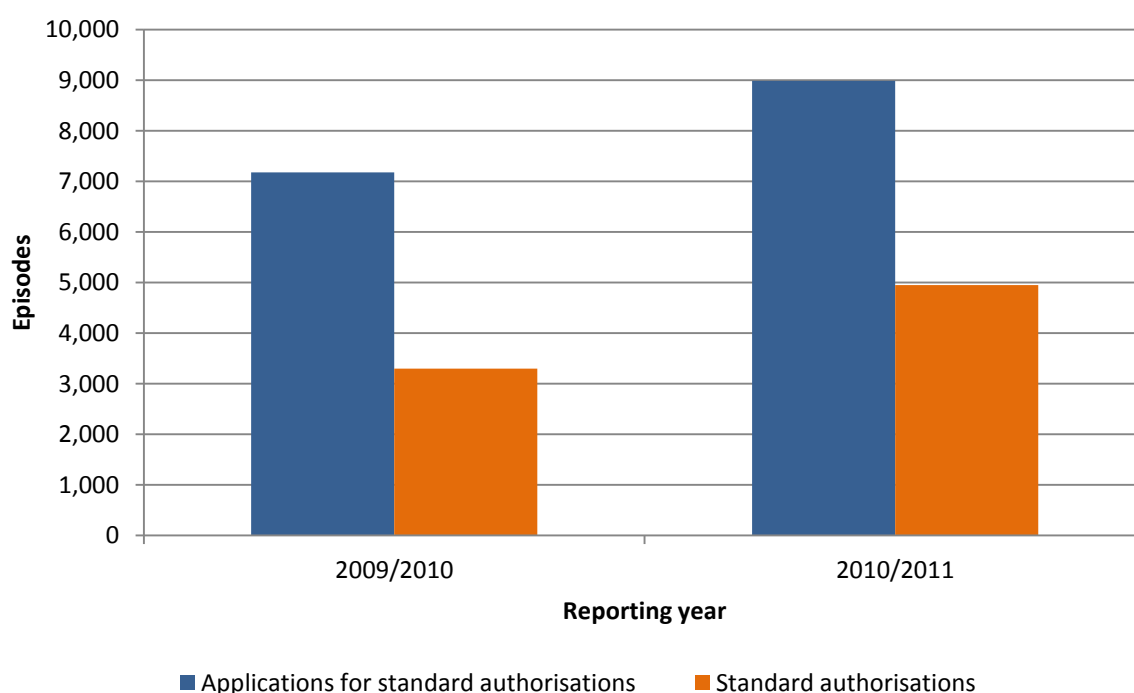


Figure 4.6. A bar chart showing the number of applications for a standard authorisation under the DOLS regime that took place in each reporting year, along with the number of authorisations granted by the relevant supervisory bodies.

³³ *Ibid.* The Department of Health anticipated that there would be 18,600 applications for standard authorisations during 2010/11, of which only twenty-five *per cent* would be authorised.

2.1.3. The Impervious Longer-term Trend

The other way in which the 2007 Act confounds expectations is that it appears to have had *no* discernible impact on the long-term rate of compulsory admissions between 1987 and 2012 (see *figure 4.7*) at all. Did those commentators who contended that the 2007 Act would lead to more detentions in hospital get it wrong?

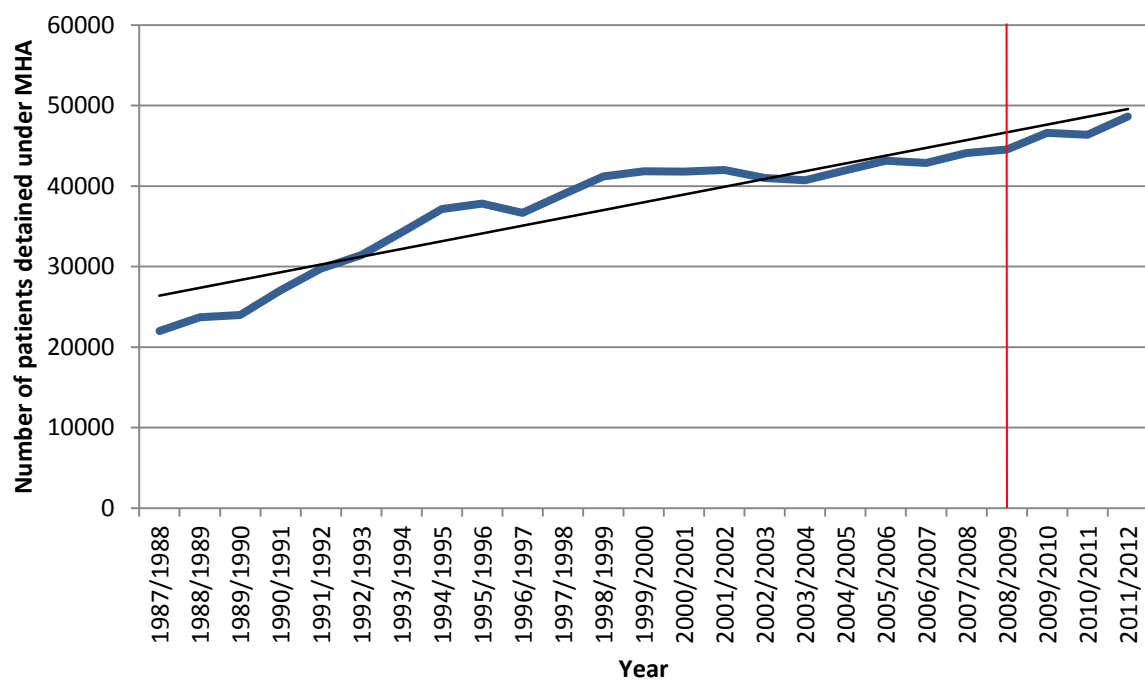


Figure 4.7. A line graph showing the number of detentions under the MHA each year from 1987/88 to 2011/12. The trend line shows the direction of the long-term trend over the last twenty-five years. The red line marks the point at which the 2007 Act's reforms became operational.³⁴

In one sense, they were quite correct. The data we have considered so far have shown a clear increase in the number of people detained in hospital since 2008. It cannot be denied that since the 2007 Act was introduced more people have been admitted to and detained in hospitals than at any other time in the history of English mental health legislation. It is also true that the number of people admitted to hospital under the MHA continues to rise

³⁴ CQC 09/10, *supra* n.18, at p19.

steadily. Yet it is unclear whether the 2007 Act is responsible for this. While the increases in the number and rate of detentions might *correlate* with the reforms, it does not necessarily follow that they are the actual *cause*. Indeed, the long-term trend suggests that the 2007 Act has had nothing to do with it at all. According to the data presented in *figure 4.7*, the trend in admissions under the MHA was growing prior to the 2007 Act's reforms and there was no sharp upturn after they were enacted. In the twenty-five reporting years between 1987/88 and 2011/12 (inclusive) the total number of annual detentions grew in fully twenty of them.³⁵ The trend line in *figure 4.7* shows that between 1993/94 and 2002/03 the number of admissions under the MHA actually ran *above* the twenty-five year rate. Since the 2007 Act came into force, the number of admissions is running slightly *below* that trend, suggesting that, if anything, the broader commitment criteria have maintained a *slower* rate of detentions that started in 2006. The statistics further suggest that the changes in the rate of admission occurred notwithstanding the fact that there were no major reforms to the original MHA between 1987 and 2008. Indeed, they apparently occurred without the presumed 'legalism' of the 1983 Act having any inhibiting effect on decision-making whatsoever. Far from presaging a massive upsurge in the deployment of the compulsory powers and a departure from the pattern set by the original 1983 Act, the post-2007 Act era is characterised by the continuation of a steady upward trend. We might conclude that if the 2007 Act has had any impact on mental health decision-making at all, it has brought the law into line with pre-existing practices.

Of course, there are many reasons why the number of detentions under the MHA may grow each year which are unrelated to the statutory regime. There is no cap on the number

³⁵ There were decreases in the number of admissions on the previous year in 1996/97, 2000/01, 2002/03, 2003/04 and 2006/07.

of people that can be admitted to hospital under the MHA. It may be that even more people are now suffering from mental disorders and warrant greater levels of compulsory care and treatment. Population growth may bring a larger proportion of people within the ambit of the legislation. Social and economic factors, such as the impact of recession or unemployment, might explain why certain years see large increases in the number of admissions. These factors might explain why there are record numbers of people subject to the MHA. Yet what is compelling about the data in *figure 4.6* is how inexorable the increase in the rate of admissions has been. It raises an important question that warrants further discussion: to what extent do changes to mental health legislation actually achieve their policy objectives?

The statistical evidence tells us that the post-2007 Act era is indeed characterised by more control and less liberty when compared to the original MHA. However, the data show that an upward trend in the number of detentions was happening long before the government decided to amend the 1983 Act. While there may be more control of patients with mental disorder, how far the 2007 Act is responsible for that is unclear.

2.2. The Empirical Evidence

At the time of writing, there are virtually no analyses of the general impact of the 2007 Act. While there have been empirical studies of the SCT regime,³⁶ very little is known about

³⁶ See, e.g., S. Dye *et al*, 'Supervised Community Treatment: 2-Year Follow-up Study in Suffolk' (2012) 36 *The Psychiatrist* 298; S. Lawton-Smith, 'Supervised Community Treatment' (2011) 35 *The Psychiatrist* 197; S. Lawton-Smith, *Briefing Paper 2: Supervised Community Treatment*, Mental Health Alliance, August 2010 (Available at: http://www.mentalhealthalliance.org.uk/resources/SCT_briefing_paper.pdf. Accessed: 14 November 2012). There has also been a major study of the use of Community Treatment Orders since they were introduced. Publication of the findings of the Oxford Community Treatment Order Evaluation Trial (OCTET) is forthcoming at the time of writing. For details of the project methodology

the effects of the Act's other amendments. This is unsurprising: the amended MHA has only been operational for four years, making it still too early to justify a rigorous comparative study of mental health practice before and after the 2007 Act. There is also the added complication of the DOLS, whose relationship with the MHA is a source of continuing confusion. Yet it is curious that few researchers have sought to establish whether the reforms have justified the controversy that surrounded their formulation.

The only study so far that has evaluated the principal changes introduced by the 2007 Act was a scoping project funded by Mersey Care NHS Trust, a specialist public mental health service based on Merseyside in north-west England.³⁷ The research team behind *An Investigation into Initial Institutional and Individual Responses to the Mental Health Act 2007: Its Impact on Perceived Patient Risk Profiles and Responding Decision-making*³⁸ carried out twenty hours of qualitative interviews with key informant decision-makers from various professional groups working for the Trust. All of the participants either deployed, or had administrative responsibilities related to, the MHA's compulsory powers on a regular basis; some were consultant psychiatrists, others were approved mental health professionals (AMHPs). The research team asked each participant about his or her understanding of the concept of risk and to evaluate the impact that the 2007 Act had had on his or her practice.

see T. Burns *et al*, 'The Oxford Community Treatment Order Evaluation Trial (OCTET)' (2008) 32 *The Psychiatrist* 400.

³⁷ Further details can be found on the Mersey Care NHS Trust website: <http://www.merseycare.nhs.uk/>.

³⁸ N. Glover-Thomas, *An Investigation into Initial Institutional and Individual Responses to the Mental Health Act 2007: Its Impact on Perceived Patient Risk Profiles and Responding Decision-making*, Liverpool: the University of Liverpool, 2011 ('Mersey Care study'). See also N. Glover-Thomas, 'The Age of Risk: Risk Perception and Determination Following the Mental Health Act 2007' (2011) 19 *Medical Law Review* 581 ('Glover-Thomas 2011'); N. Glover-Thomas, 'The Mental Health Act 2007 in England and Wales: the Impact on Perceived Patient Risk Profiles' (2010) 29(4) *Journal of Medicine and Law* 593.

The participants' responses to these questions offer an interesting insight into the practical consequences of mental health law and policy. There are two key questions that the Mersey Care study asks which are most relevant here: first, how do decision-makers understand and interpret risk in light of the 2007 Act, and, secondly, what have been the consequences of broadening the MHA's commitment criteria?

2.2.1. How Do Decision-makers Understand and Interpret Risk in Light of the 2007 Act?

The Mersey Care study found that the legal problem with risk which we considered in chapter 3 has demonstrable practical consequences. The study's participants were only too aware of the absence of a fixed definition of 'risk' in the MHA.³⁹ They appeared to reconcile the fact that risk is 'encountered on a regular basis' with the reality that there is 'no accepted definition of it'.⁴⁰ As Glover-Thomas points out, many participants were fully aware of the 'ubiquitous' nature of risk; decision-makers appreciate that the concept is the 'universal currency' of mental health practice and manage the incongruity of not actually knowing what it means.⁴¹ Many admitted to relying on self-authored 'working definitions' of risk.⁴² These could be esoteric ('risk is a slightly wider version of safety'), circular ('risk is about risk'),⁴³ or divisible ('"significant" risk');⁴⁴ or they could stem from either paraphrasing

³⁹ Glover-Thomas 2011, *supra* n.38, at p588.

⁴⁰ Mersey Care study, *supra* n.38, at p21.

⁴¹ Glover-Thomas 2011, *supra* n.38, at p594.

⁴² Glover-Thomas 2011, *supra* n.38, at p588. See also Mersey Care study, *supra* n.38, at pp20, 30, 34-5.

⁴³ Mersey Care study, *supra* n.38, at p20.

⁴⁴ Mersey Care study, *supra* n.38, at pp29, 32

the statutory commitment criteria ('risk is something that can't be managed safely in the community')⁴⁵ or inserting new words into the legislation ('you must make a distinction between risk of harm and risk of dangerousness; they have two different meanings within the Act').⁴⁶ It is not difficult to see how decision-making may become characterised by inconsistency. Mental health practitioners have clearly sought to fill the vacuum left by the absence of a definition of risk with their own interpretations of the concept. The result is 'tremendous variation' in the way in which decision-makers understand and interpret it.⁴⁷ This variation appears to be completely arbitrary; there is no connection between a practitioner's professional background and a particular interpretation of risk,⁴⁸ nor do the statutory provisions provide any discernible guiding force.⁴⁹ Participants' explicit recognition that risk can relate to anything on a 'continuum' reveals how broadly the concept is construed in practice.⁵⁰ Such open-endedness makes it inevitable that there will be a gap between legal policy and practical reality.

Yet the question for present purposes is whether the 2007 Act is responsible for this; or at least whether it has aggravated the situation. On this point, the Mersey Care study is rather equivocal. Some participants thought that the 2007 Act had required decision-makers

⁴⁵ Mersey Care study, *supra* n.38, at p30; Glover-Thomas 2011, *supra* n.38, at p588.

⁴⁶ Mersey Care study, *supra* n.38, at pp32, 36.

⁴⁷ Mersey Care study, *supra* n.38, at p61.

⁴⁸ Mersey Care study, *supra* n.38, at p20; Glover-Thomas 2011, *supra* n.38, at p588.

⁴⁹ Mersey Care study, *supra* n.38, at pp 25 and 28.

⁵⁰ Mersey Care study, *supra* n.38, at p28. See also pp37-50, where the participants reject the compilation of a 'recipe' of risks as impractical given how many factors can be germane to a patient's health or safety or to those of others.

to recalibrate their working understanding of risk.⁵¹ Just under half of the sample thought erroneously that the amendments had introduced a broader formulation of risk into the commitment criteria.⁵² This is not in fact the case: the original MHA's risk formula was left untouched by the reforms. While the 2007 Act may have lowered the commitment threshold, it did not in any way augment the risk formula. In other words, there should be no essential difference between practitioners' understanding and interpretations of risk before and after the amendments came into force. For the most part, the participants in the Mersey Care study recognised this point; one acknowledged that risk 'is the principal reason for recommending detention...but then it always was';⁵³ another denied that the 2007 Act had made much difference because risk has 'always been the underpinning of each of the Mental Health Acts'.⁵⁴ Most of the participants therefore thought that the 2007 Act represented continuity rather than change.

Interestingly, some participants played down the law's ability to affect decision-makers' understanding of risk. In their view, *no* statutory provisions could have such an effect. These participants regarded risk as a matter for professional discretion rather than legal regulation. One put faith in his extensive psychiatric training and expertise;⁵⁵ others implied that there are certain social and environmental factors that might be indicative of a

⁵¹ One participant expressly stated that the 2007 Act had introduced a broader definition of 'risk', see Mersey Care study, *supra* n.38, at p29.

⁵² This was notwithstanding the fact that there has never been a statutory definition of 'risk' in the MHA. Glover-Thomas 2011, *supra* n.38, at p592.

⁵³ Mersey Care study, *supra* n.38, at p25.

⁵⁴ Mersey Care study, *supra* n.38, at p24.

⁵⁵ *Ibid.*

patient's risk to which only qualified practitioners would be sensitive.⁵⁶ These participants believed that they possessed special knowledge about risk and, for that reason, denied that the 2007 Act would make a difference. This faith in professional instincts stems from a belief that mental health decision-making is consistent by virtue of a kind of spontaneous order. As one participant put it, if 100 sets of decision-makers examined 100 patients they would reach virtually the same conclusions about each case.⁵⁷ While this degree of unanimity is unlikely (see part 4.2), it suggests that most decision-makers expect that their conclusions about a patient will comply with the practices of a responsible body of professional opinion. Decision-makers' professional instincts thereby render the law redundant.

The Mersey Care study shows that the problems with risk have practical consequences. The MHA's lack of a definition means that practitioners devise their own 'working definitions' which bear little resemblance to the letter or spirit of the MHA. What is not clear, however, is the extent to which the 2007 Act can be said to have contributed to greater levels of inconsistency and uncertainty and thereby jeopardised liberty. The Mersey Care study suggests that mental health decision-makers have continued to (mis)understand and interpret risk in the same way that they did under the original 1983 Act. While a minority of participants thought that the 2007 Act had ushered in an era of risk averse decision-making, it seems for the most part that patients with mental disorder are no more likely to be considered a risk today than they were ten years ago. If the Mersey Care study is representative of the impact of the 2007 Act then it suggests that the reforms have not jeopardised liberty or facilitated control in the way that many commentators feared.

⁵⁶ Mersey Care study, *supra* n.38, at pp31, 33.

⁵⁷ Mersey Care study, *supra* n.38, at p35.

2.2.2. What Have Been the Consequences of Broadening the MHA's Commitment Criteria?

According to Glover-Thomas, the 2007 Act has 'significantly widened' the scope of the compulsory powers by broadening the criteria for admission to hospital.⁵⁸ Do decision-makers think this is the case?

The Mersey Care study would suggest not. All of the participants acknowledged that the 2007 Act had amended the original 1983 Act. Yet only a handful actually thought that it had made a positive difference.⁵⁹ For the most part, the study's participants were either indifferent to the amendments or welcomed them lukewarmly insofar as they brought the law into line with pre-existing practices.⁶⁰ Perhaps the biggest substantive reform which some participants mentioned was the definite inclusion of personality disorders within the scope of the simpler definition of 'mental disorder' and the admission for treatment provisions.⁶¹ Apart from that, one participant's assessment of the 2007 Act – that it was 'much ado about nothing'⁶² – encapsulated the sentiments of a vast majority of her co-participants in the sample. Some were disappointed that more radical reforms had not been

⁵⁸ Glover Thomas 2011, *supra* n.38, at p604.

⁵⁹ One participant hailed, rather vaguely, the 2007 Act's 'more pragmatic' character; another thought that the new definition of 'mental disorder' made life for decision-makers 'a lot easier'; a third participant thought that his job was now 'slightly easier' than it had been under the original 1983 Act; and a fourth thought that decision-makers could 'probably' justify making greater use of the compulsory powers since the 2007 Act came into force. See Mersey Care study, *supra* n.38, at pp65-7, 70.

⁶⁰ Glover-Thomas 2011, *supra* n.38, at p605.

⁶¹ Even then the participants were not wholly enamoured with the result, referring to the 2007 Act as having 'opened the floodgates' or bringing essentially untreatable patients within the reach of the compulsory powers. See Mersey Care study, *supra* n.38, at p66; also pp65, 70, 72.

⁶² Mersey Care study, *supra* n.38, at p66.

forthcoming.⁶³ Others stated that the processes and reasons for detaining people with mental disorders under the MHA were much the same as they had always been.⁶⁴ A consultant psychiatrist doubted that the amendments had had any 'major effect' on his decision-making;⁶⁵ an AMHP denied that the 2007 Act had implemented the 'big transformation' that many of his colleagues were expecting;⁶⁶ and a medico-legal administrator suspected that the reforms would not make 'a blind bit of difference'.⁶⁷ Almost all of the participants thought that the 2007 Act had merely tinkered at the margins of the MHA.

Once again we can see a gap between legal policy and practical reality. In spite of policy-makers' explicit intention to lower the threshold at which the compulsory powers can be engaged, the Mersey Care study suggests that mental health practitioners have taken a 'business as usual' attitude since the amendments came into force. If this represents practice across the board then decision-making in the post-2007 Act era is not fundamentally distinct from that which was observed in the 1980s. The study does not contain any evidence to suggest that decision-making has become any less consistent or more inordinately focused on social control since 2008. The implication is that if the broader commitment powers have made it easier for decision-makers to detain people under the MHA then only a small number of patients are actually affected by them. It would seem that policy-makers either overstated or overestimated the obstructive nature of the original

⁶³ Mersey Care study, *supra* n.38, at p70.

⁶⁴ Mersey Care study, *supra* n.38, at p69.

⁶⁵ Mersey Care study, *supra* n.38, at p68.

⁶⁶ Mersey Care study, *supra* n.38, at p69.

⁶⁷ Mersey Care study, *supra* n.38, at p72.

1983 Act's legalism and therefore the case for reform. Indeed, it may be that some practitioners are now acutely aware that they have a responsibility to take steps to ensure that they do not abuse the MHA's broader commitment criteria. One clinical participant in the study admitted that he 'would be very worried being a patient on the receiving end of that Act with a psychiatrist...determined that there is something wrong with me...'⁶⁸ This suggests that the 2007 Act may have brought the gravity of psychiatrists' responsibilities into stark relief, thereby encouraging them not to take 'sectioning' decisions lightly. In any event, the Mersey Care study suggests that the consequences of broadening the MHA's commitment criteria appear to have been negligible.

In her analysis of the Mersey Care study, Glover-Thomas says that it 'is difficult to resist the conclusion that patients' rights will become increasingly secondary to public safety in the post-2007 Act era'.⁶⁹ In fact it is difficult to see how the study supports that conclusion: there is no evidence within its findings to suggest that decision-makers interpret risk or engage the commitment criteria any differently in the post-2007 Act era. True, the concept of risk is problematic in a legal context and the MHA's commitment criteria are indisputably broader than they were under the original 1983 Act. Yet this has apparently not translated into a distinct epoch of mental health decision-making in which patients are subject to ever-greater levels of control. In respect of risk, the Mersey Care study does not reveal anything that could not have been established prior to the 2007 Act. Similarly, where the impact of those reforms is concerned, there has not been a departure from the decision-making

⁶⁸ Mersey Care study, *supra* n.38, at p67.

⁶⁹ Glover-Thomas 2011, *supra* n.38, at p605.

practices that preceded them. It would seem that the available empirical evidence defines the post-2007 Act era as a period of continuity, not change.

All this raises two important questions. First, do reforms to mental health law always achieve their policy objectives? If so, the 2007 Act's failure to achieve what it was apparently intended to do might suggest that the legislation was badly drafted or misconceived; if not, then the negligible impact of the reforms should not come as a great surprise. Secondly, does the law always map mental health practice? If so, it may be that decision-makers are deliberately departing from the rules; if not, there may be a case to argue that reforming mental health law to improve health outcomes is a futile exercise. The remainder of this chapter seeks to answer these questions.

3. Do Reforms to Mental Health Laws Always Achieve their Policy Objectives?

3.1. The Evidence

One of the earliest studies of the impact of legislative reform on mental health practice evaluated California's Lanterman-Petris-Short (LPS) Act.⁷⁰ The Act of 1969, which was amended in 1974, was designed to tighten the existing commitment criteria for admission to hospital. In shifting to legalism, the LPS Act was intended to have the opposite effect to the 2007 Act; i.e., it sought to add more robust procedural protections to the legal framework. Warren observed 100 *habeas corpus* petition hearings in California and found that there was divergence between legislative intent and statutory language on one hand

⁷⁰ C.A.B. Warren, 'Involuntary Commitment for Mental Disorder: the Application of California's Lanterman-Petris-Short Act' (1977) 11 *Law and Society Review* 629.

and the judicial and administrative interpretation of them on the other.⁷¹ For example, while the LPS Act required evidence to be adduced that would be probative of the imminence and seriousness of a patient's future danger, 'these criteria were simply ignored in most of the 100 *habeas corpus* proceedings...'⁷² More importantly, Warren found evidence that amendments to one statutory basis for admission would lead to 'squeezing' elsewhere.⁷³ For example, where a decision-maker found that the LPS Act had tightened a particular criterion so as to preclude a patient's compulsory admission under it, he would get around this problem by shoehorning that patient under another basis.⁷⁴ Warren concluded that decision-makers were not strictly applying the statutory criteria for civil commitment and frequently 'bargained them down', implying that they made selective and strategic use of the law rather than respecting it as the limit of clinical authority. This study was among the first to identify a gap between law and practice. In Warren's view, there are three ways in which one might reconcile this gap. First, the legislature can change the law to bring it into line with actual practice. Secondly, decision-makers could alter their practices in order to comply with the law. Thirdly, the gap could be regarded 'as both inevitable and ubiquitous'.⁷⁵ The implication behind having to make this choice, however, is that the law's influence on mental health practice is weak. It should not come as a surprise that a later study of the consequences of the LPS Act found that far from lowering the rate of

⁷¹ *Ibid*, at p631.

⁷² *Ibid*, at p642.

⁷³ *Ibid*, at pp646-7.

⁷⁴ We saw a similar 'squeezing' effect at play in part 2.1.2 above, in which the fall in the number of section 3 admissions for treatment was attributed to the rise in the number of recalls and revocations of CTOs

⁷⁵ Warren, *supra* n.70, at p648.

involuntary admissions it had in fact *increased* it.⁷⁶ This suggests that the statutory regime failed to fulfil its legalistic policy objectives.

These findings are not unique. Later research has found that changes to mental health laws *rarely* affect long-term rates of admission to hospital. Luckey and Berman examined the impact of a new mental health statute introduced in Nebraska in 1976.⁷⁷ The Act required ‘clear and convincing proof’ that a patient was (i) mentally ill and (ii) dangerous to either himself or other people before doctors could commit him to hospital. This represented a higher threshold for compulsion than had previously existed in the state. The researchers found that the number of involuntary admissions to hospital fell immediately following the enactment of the new laws.⁷⁸ This short-term fall is obviously consistent with a tightening of commitment criteria. However, Luckey and Berman found that this effect was only temporary: within eighteen months, the number of admissions had returned to the level it would have been projected to reach without any change in the law.⁷⁹ They concluded that the admission statistics showed that there is ‘the potential for incongruence between the law as written and the law as implemented’.⁸⁰ Similarly, Frydman evaluated the effects of a revision of the mental health laws of Kansas in 1976.⁸¹ He found that within

⁷⁶ H.R. Lamb *et al*, ‘Legislating Social Control of the Mentally Ill in California’ (1981) 138(3) *American Journal of Psychiatry* 334.

⁷⁷ J.W. Luckey and J.J. Berman, ‘Effects of a New Commitment Law on Involuntary Admissions and Service Utilisation Patterns’ (1976) 3(3) *Law and Human Behaviour* 149.

⁷⁸ *Ibid*, at p159.

⁷⁹ *Ibid*, at p154.

⁸⁰ *Ibid*, at p160.

⁸¹ L.L. Frydman, ‘Effects of Psychiatric Legislation: an Example from Kansas’ (1980) 8 *Journal of Law and Psychiatry* 73.

two years of the reforms there was a marked drop in the number of commitment petitions and hearings.⁸² Significantly, there was a fourteen *per cent* decline in the rate of involuntary admissions. Yet, the new law did not have a long-lasting effect: the average daily inpatient population, the rate of admission, and the average length of stay in three Kansas State hospitals were not affected by the new statutory regime in the long term.⁸³ Frydman's work is therefore consistent with Luckey and Berman's findings: reforms which introduce a more exacting legalistic standard appear only to have a short-term impact on the number and rate of involuntary admissions. Frydman also made another interesting discovery: the decline in the number of commitment proceedings began in 1975, fully two years *before* the enactment of the new legislation.⁸⁴ In his view, this may be attributable to the adverse publicity that the reforms received prior to their introduction. In any event, the study suggests two things which may be relevant to the 2007 Act. First, decision-makers did not function in a way that reflected the purported constraints of the new statutory regime after it had been in force for two years. Secondly, pre-reform controversies can affect decision-making practices, notwithstanding the fact that the proposed amendments may not be legally binding. The law is therefore less determinative than one might expect.

In 1978, the Legislative Assembly of Ontario, Canada, also embraced legalism and amended its Mental Health Act accordingly. A number of subsequent studies found that the reforms had made no significant difference to decision-making processes and outcomes in the long-term. Page examined the commitment papers of seventy-five people admitted to

⁸² *Ibid*, at p84.

⁸³ *Ibid*, at p94.

⁸⁴ *Ibid*, at p84.

hospital under the legislation.⁸⁵ In the eight months following the amendments, the frequency of involuntary admissions fell significantly from a mean of 14.3 a month to only 7.7. In the short-term, the amendments had had a considerable influence on mental health professionals' decision-making. Yet Page found that the same types of individuals were being committed under the amended statutory regime as had been captured by its original incarnation.⁸⁶ In his view, the decision-makers acknowledged that the law 'never completely reflects all possible events in the real world' and therefore responded by departing from the letter or spirit of the legislation.⁸⁷ This probably explains why, in another study, Page found that the 1978 amendments had had no bearing on decision-makers' interpretation of the law's 'operational definitions'.⁸⁸ He concluded that even explicit legal provisions are unlikely to impede a physician who is 'genuinely of the opinion' that compulsory commitment 'is in the best interests of the patient's immediate welfare and condition'.⁸⁹ While Page identified an initial fall in the number of involuntary admissions, later studies found that the 1978 reforms had not had the effect of reducing the rate of detentions in the longer-term.⁹⁰ Bagby thought that by the second post-reform year the number of compulsory admissions began to increase in Ontario after an initial decline.⁹¹ Martin and Cheung also found that

⁸⁵ S. Page, 'New Civil Commitment Legislation: the Relevance of Commitment "Criteria"' (1980) 25 *Canadian Journal of Psychiatry* 646.

⁸⁶ *Ibid*, at p649.

⁸⁷ *Ibid*.

⁸⁸ S. Page, 'Civil Commitment: Operational Definition of New Criteria' (1981) 26(6) *Canadian Journal of Psychiatry* 419.

⁸⁹ *Ibid*, at p420.

⁹⁰ R.M. Bagby, 'The Effects of Legislative Reform on Admission Rates to Psychiatric Units of General Hospitals' (1987) 10 *International Journal of Law and Psychiatry* 383.

⁹¹ *Ibid*, at p391.

mental health laws had had little or no effect on long-term commitment practices in Ontario over a longer period.⁹² In their view, there was no causal relationship between the commitment rate in Ontario and successive amendments to the relevant legislation. There had been a steep decline in the proportion of involuntary admissions to psychiatric hospitals *well before* the enactment of any legislation that might be expected to have had such an effect.⁹³ Conversely, the stricter criteria incorporated into the statutory regime actually precipitated an *increase* in the proportion of involuntary admissions to hospital from twenty-seven *per cent* in 1978 to thirty-six *per cent* by 1980. Tighter commitment criteria in the Ontarian mental health statute had not had their intended effect.⁹⁴

Interestingly, a similar phenomenon occurred in England following the introduction of the 1983 Act. Barnes *et al* suggest that the effect of the 1983 Act confounded expectations at the time.⁹⁵ They studied the requests made to approved social workers (ASWs) following the introduction of the 1983 Act and compared their results with those of studies that predated the new legislation. First, they found that the 1983 Act had led to a kind of ‘squeezing’ whereby ASWs received fewer requests to authorise emergency admission but experienced a concomitant rise in the number of requests for admission for assessment.⁹⁶ This meant that the statistics underestimated the overall use of compulsory detention considerably because for every two people admitted formally there was another patient

⁹² B.A. Martin and K.D. Cheung, ‘Civil Commitment Trends in Ontario: the Effect of Legislation on Clinical Practice’ (1985) 30 *Canadian Journal of Psychiatry* 259.

⁹³ *Ibid*, at p263.

⁹⁴ *Ibid*.

⁹⁵ M. Barnes *et al*, *Sectioned: Social Services and the 1983 Mental Health Act*, London: Routledge, 1990.

⁹⁶ *Ibid*, at p60.

either transferred from one section to another or sectioned after arriving at hospital voluntarily.⁹⁷ Secondly, they found that the 1983 Act's legalism had not translated into a reduction in the number of compulsory admissions.⁹⁸ While it is true that between 1982 and 1984 there was a 9 *per cent* fall in the number of formal detentions under the MHA, 'this [was] in-step with the steady fall in the number of formal admissions that preceded the Act'.⁹⁹ Then, between 1984 and 1985, the number of formal admissions actually *rose*, thereby casting doubt on the accepted view that legalistic criteria lead to fewer detentions. Barnes *et al* admit that other factors might have contributed to this increase, e.g., socioeconomic conditions. Nonetheless, the legal framework is a poor predictor of the way decision-makers function. It may be that taking 'legal' decisions is not a priority for mental health professionals. For that reason, amendments which seek to introduce tougher admission criteria may not operate as intended.

The effect works the other way too. Where reforms have sought to *broaden* compulsory commitment criteria in order to boost decision-makers' discretion, they succeed in the short term. Durham and LaFond evaluated the effect of amendments to mental health laws in Washington in 1979, which expanded the state's civil commitment powers.¹⁰⁰ They made two interesting discoveries. First, immediately after the change in the law the number of patients admitted to hospital increased significantly.¹⁰¹ The absolute number of involuntary

⁹⁷ *Ibid*, at p61.

⁹⁸ *Ibid*.

⁹⁹ *Ibid*, at p67.

¹⁰⁰ M.L. Durham and J.Q. LaFond, 'The Empirical Consequences and Policy Implications of Broadening the Statutory Criteria for Civil Commitment' (1985) 3 *Yale Law and Policy Review* 395.

¹⁰¹ *Ibid*, at p401.

admissions increased by 91 *per cent* in the first full year and there was a concurrent decline in the number of voluntary admissions by nearly 47 *per cent*. In the year following the change in the law, the probability of a patient being admitted to hospital on a compulsory basis increased from 47.3 to 63.2 *per cent*.¹⁰² By expanding the civil commitment powers, Washington lawmakers effectively collapsed the distinction between voluntary and involuntary patients and fundamentally changed the decision-making dynamic. The amendments made it easier to deploy the compulsory powers and thereby disincentivised decision-makers from working outside the legislation. As an incidental effect, patients stayed in hospital for longer and became chronic users of mental health services.¹⁰³ This put pressure on resources, leading Durham and LaFond to conclude that loosening admission criteria jeopardises ‘therapeutic justice’.¹⁰⁴

Secondly, Durham and LaFond found that the same ‘anticipation effect’ which prefaces the introduction of stricter commitment criteria also occurred when decision-makers enjoyed greater clinical freedom.¹⁰⁵ There was an abrupt 45.2 *per cent* increase in the number of involuntary admissions in Washington fully nine months *before* the effective date of the new statute.¹⁰⁶ Once again we can see the impact of the broader policy context which the contemporary legal framework does little to inhibit.

¹⁰² *Ibid*, at p419.

¹⁰³ *Ibid*.

¹⁰⁴ M.L. Durham and J.Q. LaFond, ‘The Impact of Expanding a State’s Therapeutic Commitment Authority’ in D.B. Wexler (ed.) *Therapeutic Jurisprudence: the Law as a Therapeutic Agent*, Durham, North Carolina: Carolina Academic Press, 1990, at p125.

¹⁰⁵ Durham and LaFond, *supra* n.100, at pp410, 418.

¹⁰⁶ *Ibid*, at p416.

Durham and LaFond did not chart the longer-term effects of the Washingtonian reforms. According to Bagby and Atkinson, however, any amendments to mental health statutes follow the same pattern: they achieve their policy objectives for up to two years before their effectiveness diminishes.¹⁰⁷ They conclude that there is a strong possibility that mental health professionals do not implement the law as intended.¹⁰⁸ Equally, it may be that they simply do not see themselves as responsible for applying the law at all and so remain unaffected by legislative upheavals. In any event, we may reasonably doubt the law's capacity to achieve its policy objectives.

It is not true, however, that reforming mental health law is inevitably a futile exercise. Peters *et al* examined the impact of amendments to Florida's mental health legislation in 1982.¹⁰⁹ They reviewed eighty commitment hearings which convened before and after the reforms took effect. The researchers expected to observe a decline in the number of compulsory admissions because the new legal framework explicitly defined the degree of dangerousness that would be necessary to trigger the commitment powers. Peters *et al* found what they had expected: in the first month after the reforms were enacted the number of involuntary admissions registered their single biggest decline in four years.¹¹⁰ The researchers concluded that substantive changes to commitment criteria appear to be the single most accurate predictor of the number of involuntary admissions.¹¹¹ Similarly, in a

¹⁰⁷ R.M. Bagby and L. Atkinson, 'The Effects of Legislative Reform on Civil Commitment Admission Rates: a Critical Analysis' (1988) 6(1) *Behavioural Sciences and the Law* 45, at p56.

¹⁰⁸ *Ibid*, at p59.

¹⁰⁹ R. Peters *et al*, 'The Effects of Statutory Change on the Civil Commitment of the Mentally Ill' (1987) 11(2) *Law and Human Behaviour* 73.

¹¹⁰ *Ibid*, at p87.

¹¹¹ *Ibid*, at p77.

review of the statutory regimes of thirteen US states, Wanck found that in ten of them the outcome achieved the legislation's policy objectives.¹¹² In seven of the states a fall in the rate of involuntary hospitalisation followed amendments which narrowed the commitment criteria, while in the other three the introduction of broader provisions prefaced a significant increase in the number of detentions.¹¹³ Wanck concluded that amendments to state laws influence admission rates to such an extent that in most cases they will have their intended effect.

There are a number of points to make here. First, Peters *et al* focused on the impact of statutory reform on decision-making in commitment hearings. Given that legally-constituted panels formed the gateway to civil commitment in Florida even before lawmakers introduced more exacting criteria, we can assume that the framework was already fairly legalistic. There may be an argument then that 'legal' decision-makers already accustomed to legalistic processes are better equipped than mental health professionals to respond to statutory reforms in the way that policy-makers intended. As a result, amendments to mental health statutes may be more likely to achieve their policy objectives where lawyers are the principal decision-makers. Secondly, neither Peters *et al* nor Wanck discussed the long-term consequences of the legislative reforms they studied. We already know that amendments to statutory frameworks seem typically to achieve their policy objectives in the *short-term*. Two years or more *after* the reforms take effect, however, and the rate of admissions tends to return to previous levels. Longer-term analyses may have revealed that the impact of the reforms was much less significant.

¹¹² B. Wanck, 'Two Decades of Involuntary Hospitalisation Legislation' (1984) 141(1) *American Journal of Psychiatry* 33.

¹¹³ *Ibid*, at p35.

Writing in the mid-1990s after a period of radical change in mental health law in the United States, Appelbaum reviewed the evidence and argued that reforms to mental health legislation have less impact than expected on rates of commitment.¹¹⁴ In his view, the consequences of mental health law reform are limited.¹¹⁵ Whether mental health legislation is medicalistic or legalistic appears to make little material difference to the operation of civil commitment powers. In general terms, law reforms in this field have had no bearing on who is committed to hospital or on the care and treatment which they receive.¹¹⁶ This raises important questions about the nature and purpose of mental health law: why do we spend so much time formulating policy and drafting legislation when the same people will find themselves detained in hospital? Surely in these circumstances law and policy are simply redundant? According to Appelbaum, the most profound effects of mental health law reform appear to be 'of limited duration, with the situation tending to return toward the pre-reform baseline over time'.¹¹⁷ This is certainly consistent with the findings from the studies we have considered in this part of the chapter. For that reason, Appelbaum thought that instead of embarking on 'inefficient and fruitless' attempts to find 'the most satisfying combination of words to describe those eligible for commitment', attention would be better concentrated on guaranteeing investment in mental health services.¹¹⁸

The evidence suggests that the assumption that mental health law is an effective vehicle to fulfil policy objectives is misguided. There are many factors outside the law that influence

¹¹⁴ P. Appelbaum, *Almost a Revolution*, Oxford: OUP, 1994, at pp40, 41.

¹¹⁵ *Ibid*, at p210.

¹¹⁶ *Ibid*, at p212.

¹¹⁷ *Ibid*.

¹¹⁸ *Ibid*, at p52-3.

the number and rate of compulsory admissions to hospital. In the long-term, these trends seem largely resistant to policy innovations and legislative reforms.

3.2. The Verdict

Mental health law reforms do not always achieve their policy objectives. Amendments to mental health statutes have consequences which policy- and law-makers presumably did not intend. Even where the provisions have been explicitly-worded in order to generate a particular outcome they have on occasion had the opposite effect in practice; stricter commitment powers have not necessarily led to fewer admissions and it has not always been the case that a surge in detentions follows the introduction of broader criteria. The fact that the 2007 Act has not led to a significant increase in the rate or number of admissions is therefore not unusual. To what extent can we argue that the 2007 Act's apparent failure to fulfil its policy objectives is consistent with the evidence from the literature?

In one important way, the admissions statistics in the post-2007 Act era exhibit a similar trend to those identified in other studies. *Figures 4.2, 4.4 and 4.5* show that the 2007 Act has led to the same sort of 'squeezing' that Warren and Barnes *et al* discovered in their respective studies. Indeed, given that these researchers evaluated the impact of reforms designed to *tighten* commitment criteria, the process might be more properly described as 'de-squeezing' when applied to the medicalistic 2007 Act. As a result of this process, the number of people held under section 3 has fallen in inverse proportion to the rise in recalls and revocations of CTOs and standard authorisations under the DOLS regime. The 2007 Act's reforms have therefore contributed to fluctuations in the number of patients subject to particular sections of the MHA.

In many other respects, however, the 2007 Act seems rather unique. First, as we saw in *figures 4.1 and 4.7*, there was no sudden surge in the number of admissions when the 2007 Act came into force. Whereas other studies found there to have been a discernible change in the numbers and rates of detention following legislative reform, the post-2007 Act era has continued the steady long-term upward trend that long predates the amendments. While it is true that more people are now subject to the MHA at any given time and that more patients are detained each year than was ever the case under the original 1983 Act, there is no evidence to suggest that the 2007 Act has anything to do with this. *Figure 4.7*, in particular, suggests that the rate of detentions under the MHA would still have reached its current level notwithstanding the change in the law. As a corollary, the number and rate of detentions have not returned to their pre-reform baselines since the 2007 Act came into force, principally because there was never a departure from them in the first place. The trends are by and large what one might have expected to find had one extrapolated their trajectories ten years ago. The statistics have been largely impervious to the changes that came into effect in 2008.

Secondly, there was no ‘anticipation effect’ which prefigured the 2007 Act. While other studies have found that decision-makers started operating according to new statutory regimes even before they had the force of law, no such pattern occurred in relation to the 2007 Act. True, the number of detentions rose throughout the 2000s but, once again, there is no evidence to suggest that the public debates about the nature and purpose of mental health law had anything to do with this. The number of compulsory admissions rose and continues to rise without any regard for the wording of the statutory regime that ostensibly governs it.

There is no causal link between amendments to the wording of a statute and fluctuations in the rate of compulsory admissions. This rather undermines the traditional assumption that ‘better’ mental health legislation can fulfil policy objectives and lead to better outcomes.¹¹⁹ Those who argued prior to the 2007 Act that the proposed reforms would lead to ‘the most illiberal mental health laws that this country has ever seen’¹²⁰ evidently overstated the law’s ability to translate policy into practice. In fact, some commentators have argued for a while that the question whether the law can improve mental health practice remains open.¹²¹ Nevertheless, the flawed assumption that law is a universal panacea continues to pervade scholarship. More recently, Bartlett has argued – with reference to the comprehensive provisions of Ontario’s Mental Health Act – that ‘it is simply not correct to say that the ambiguous criteria in many European statutes are the best that can be done by way of clarity’.¹²² Again, we can see that the quest for linguistic purity has taken precedence over the vicissitudes of practice.

There are two conclusions we might make here. First, only a small number of people suffering from mental disorders were beyond compulsory care and treatment under the original 1983 Act. The 2007 Act has brought them within the scope of the compulsory

¹¹⁹ See, e.g., D. Carson, ‘Dangerous People: through a Broader Conception of “Risk” and “Danger” to Better Decisions’ (1994) 3 *Expert Evidence* 51. Carson argued, at p64, that future mental health legislation should ‘go beneath verbal formulations to more explicit formulae of the values being implicitly stated’.

¹²⁰ M. Kinton, ‘Mental Health Law for the 21st Century?’ (2005) May *Journal of Mental Health Law* 57, at p68.

¹²¹ See, e.g., A. Bartlett and L. Phillips, ‘Decision-making and Mental Health Law’ in N. Eastman and J. Peay (eds.) *Law Without Enforcement: Integrating Mental Health and Justice*, Oxford: Hart Publishing Limited, 1999, at p187.

¹²² P. Bartlett, ‘A Mental Disorder of a Kind or Degree Warranting Confinement: Examining Justifications for Psychiatric Detention’ (2012) 16(6) *International Journal of Human Rights* 831, at p839.

powers, but their numbers are so insignificant that they have made virtually no impact on the admission statistics. Alternatively, the 2007 Act brought the law into line with pre-existing practices. The assumption that law and policy lead while mental health practice follows is therefore false. It is submitted that the 2007 Act has not achieved its policy objective of making decision-makers more responsive to risks. Even if it can be shown that the 2007 Act *has* accomplished its original aims, the consequences of this are likely to be so trifling that they have made little essential difference. Although there may be more control and less liberty in the post-2007 Act era, there is virtually no evidence that the 2007 Act has anything to do with it.

4. Does Mental Health Law Always Map Practice?

4.1. Getting our bearings

There is a long-standing assumption that legal rules can delimit the scope of clinical authority. This is particularly true in relation to mental health. Writing in the 1960s, Dershowitz argued that the gradual introduction of a ‘medical model’ in place of legally relevant criteria had led to ‘confusion of purpose’ and ‘needless deprivation of liberty’.¹²³ In his view, civil commitment should be a legalistic process which checks the tendency of ‘designated experts’ to over-predict the risks that a patient might pose to himself or others.¹²⁴ We can see in Dershowitz’s work the same scepticism which undoubtedly drove the retreat from medicalism in Britain, Canada and the United States during the 1970s and 1980s. Kittrie’s ‘Therapeutic Bill of Rights’ was surely cast in the same philosophical mould.

¹²³ A. Dershowitz, ‘Psychiatry in the Legal Process: “A Knife that Cuts Both Ways”’ (1967-1968) 51 *Judicature* 370, at p370.

¹²⁴ *Ibid*, at pp374, 377.

He proposed that civil commitment be underpinned by legally-enforceable principles to 'protect the fundamental rights and liberties of individuals' in a therapeutic state.¹²⁵ Kittrie believed that the growing prominence of compulsory interventions in mental health practice carried a heightened risk that decision-makers could abuse substantive due process.¹²⁶ His therapeutic Bill of Rights contained provisions which would impose limits on mental health practitioners' discretion. For example – and perhaps most relevant for present purposes – Article 3 stated that 'No social sanctions may be invoked unless the person subjected to treatment has demonstrated a clear and present danger through truly harmful behaviour which is immediately forthcoming or has already occurred'.¹²⁷ Kittrie's Bill of Rights thus sought to impose rigorous and objective commitment criteria which would carry a high threshold for intervention. Implicit in this formulation is the belief that the law serves as a supreme form of supervision over the medical domain. While Kittrie's Bill of Rights was not adopted by any legal framework, it continues to reflect assumptions about the law's ability to control and influence medical practice.

More recently, Wexler and Winick developed the notion of 'therapeutic jurisprudence'. According to its proponents, this involves the law *itself* acting as a 'therapeutic agent' by ensuring that clinical practice adheres to the 'principles of justice'.¹²⁸ Wexler thought that it is possible to craft 'legal arrangements' which can enhance therapeutic benefits whilst at

¹²⁵ N.N. Kittrie, *The Right to be Different*, London: the John Hopkins University Press, 1971, at pp402-4.

¹²⁶ *Ibid*, at p378.

¹²⁷ *Ibid*, at p403.

¹²⁸ B.J. Winick, 'The Jurisprudence of Therapeutic Jurisprudence' in D.B. Wexler and B.J. Winick (eds.) *Law in a Therapeutic Key: Developments in Therapeutic Jurisprudence*, Durham, North Carolina: Carolina Academic Press, 1996, at p646; see also D.B. Wexler, 'Putting Mental Health into Mental Health Law' (1992) 16(1) *Law and Human Behaviour* 27, at p32.

the same time protecting patients' rights.¹²⁹ How policy-makers might accomplish this ambitious goal is unclear; much of the discussion of therapeutic jurisprudence was big on rhetoric but rather less convincing about how the law could reconcile the conflict between serving as a clinical tool and protecting patients' rights.¹³⁰ Indeed, Bean argued that the MHA is essentially distinct from other legal rules.¹³¹ The legislation is loosely formulated, imposes no secondary rules governing the standard or burden of proof, and offers few legal rights for the citizen (e.g., there is no formal cautioning procedure under the MHA). Furthermore, the MHA does not require mental health professionals to give reasons for their decisions and it allows the 'sectioning' procedure to take place in secret.¹³² We can argue, therefore, that therapeutic jurisprudence requires such a distortion of legal processes that it ceases to be about 'law' at all. In any event, we can see how much mental health practice craves the prestige of legality and how compelling assumptions about the law's curative effects have been in shaping health policies. While the ideal of 'therapeutic

¹²⁹ D.B. Wexler, 'Justice, Mental Health and Therapeutic Jurisprudence' in D.B. Wexler and B.J. Winick (eds.) *Law in a Therapeutic Key: Developments in Therapeutic Jurisprudence*, Durham, North Carolina: Carolina Academic Press, 1996, at p719.

¹³⁰ Discussions about what 'therapeutic jurisprudence' actually means are maddeningly vague. See D. Carson and D.B. Wexler, 'New Approaches to Mental Health Law: Will the UK Follow the US Lead, Again?' in D.B. Wexler and B.J. Winick (eds.) *Law in a Therapeutic Key: Developments in Therapeutic Jurisprudence*, Durham, North Carolina: Carolina Academic Press, 1996, who say, at p642, that therapeutic jurisprudence involves 'opening up more choices for more people to take; it need not be a case of law *or* psychiatry, but rather one of law *and* psychiatry'. See also B.D. Sales and D.W. Shuman, 'The Newly Emerging Mental Health Law' in the same collection, who, at p800, criticise the law for 'playing at the fringe...seemingly oblivious to the larger patterns' without specifying how the law could become more engaged in clinical processes. See also D.B. Wexler, 'Grave Disability and Family Therapy: the Therapeutic Potential of Civil Libertarian Commitment Codes' in D.B. Wexler (ed.) *Therapeutic Jurisprudence: the Law as a Therapeutic Agent*, Durham, North Carolina: Carolina Academic Press, 1990, who argues – perhaps rather counter-intuitively – that broader commitment criteria 'may operate in a manner antagonistic to true therapy', whereas narrower criteria can provide decision-makers with an important therapeutic tool (at pp180; 183-4).

¹³¹ R. Bean, 'The Mental Health Act 1959: Some Issues Concerning Rule Enforcement' (1975) 2(2) *British Journal of Law and Society* 225, at p228.

¹³² *Ibid*, at p228-9.

jurisprudence' was out of fashion by the end of the 1990s, the belief that better laws foster better decision-making continues to pervade the discourse.¹³³ Indeed, Eastman argues that clinicians' knowledge of mental health law is an 'ethical imperative',¹³⁴ suggesting that they simply cannot function without it. To what extent is mental health law determinative of clinical practices?

4.2. The Evidence

A divergence between 'law on the books' and 'law in practice' has been evident for some time.¹³⁵ This is almost certainly a consequence of the distinct – and occasionally rival – philosophies of law and medicine.¹³⁶ It may also reflect the fact that law and practice will not ever be in perfect alignment and that error is an inevitable feature of the decision-making process.¹³⁷ Writing in the early 1980s, Shah pointed out that the implementation of complex public policies is very difficult, requiring diligent efforts by various administrative agencies, co-ordinated political action and investment.¹³⁸ In the likely absence of such a confluence, decision-making practices will not fully mirror the statutory framework that

¹³³ See, e.g., Bartlett, *supra* n.122.

¹³⁴ N. Eastman, 'The Need to Change Mental Health Law' in T. Heller *et al* (eds.) *Mental Health Matters: A Reader*, Basingstoke: Palgrave MacMillan, 1996, at pp209-10.

¹³⁵ S.A. Shah, 'Legal and Mental Health System Interactions: Major Development and Research Needs' (1981) 4 *International Journal of Law and Psychiatry* 219, at p230.

¹³⁶ See also, G. Richardson and O. Thorold, 'Law as a Rights Protector: Assessing the Mental Health Act 1983' in N. Eastman and J. Peay (eds.) *Law Without Enforcement: Integrating Mental Health and Justice*, Oxford: Hart Publishing Limited, 1999, who say, at p110, that while medicine can be influenced by the law it cannot adopt legal norms as its own, suggesting that there is a fundamental divide between the two fields.

¹³⁷ L.T. Wilkins, 'Directions for Corrections' (1974) 118(3) *Proceedings of the American Philosophical Society* 235, at p241.

¹³⁸ Shah, *supra* n.135.

notionally governs them. Writing more recently, Eastman and Peay have cast the problem in more straightforward terms: the rules in mental health law 'are neither clear nor effectively enforced'.¹³⁹ One might conclude that the law is therefore an imperfect means of mapping mental health decision-making. Yet there is also a deeper issue of causality here. In chapter three, we saw that mental health decision-makers can be said to act in a 'quasi-judicial' capacity. Just like judges, the motivations of mental health professionals applying the MHA are impossible to establish. As Konecni and Ebbesen point out, what decision-makers think they do, what they say they do, and what they actually do may be completely distinct.¹⁴⁰ For example, a psychiatrist may think he takes decisions that comport with the MHA, may express his belief in his ethical imperative to do so, but may actually reach a decision that lacks any adequate legal basis. Alternatively, another psychiatrist might think that the MHA is a waste of time, articulate his intention to take broader extra-legal considerations into account but reach a decision which objectively complies with the letter and spirit of the legislation. It becomes plain that asking whether the MHA maps mental practice might be too simplistic. A decision-maker might internalise the rules but reach conclusions that have no legal basis, or he might regard the MHA with utter disdain but still take decisions that are legally justified. In neither case can we say that the MHA 'maps' practice in the sense that it provides a code that all decision-makers internalise and apply. For that reason, we shall consider evidence relating to both the accuracy of decision-makers' knowledge of the law (the internal aspect) and their application of it (the external aspect).

¹³⁹ N. Eastman and J. Peay, 'Law Without Enforcement: Theory and Practice' in N. Eastman and J. Peay (eds.) *Law Without Enforcement: Integrating Mental Health and Justice*, Oxford: Hart Publishing Limited, 1999, at p8.

¹⁴⁰ V.J. Konecni and E.B. Ebbesen, 'The Mythology of Legal Decision-making' (1984) 7 *International Journal of Law and Psychiatry* 5, at p6.

4.2.1. Decision-makers' knowledge of the law

Decision-makers' knowledge of mental health law is patchy. In a study of practitioners' knowledge of the emergency hospitalisation laws in Connecticut and the District of Columbia, Affleck *et al* found that only a handful of the 294 participants had a thorough grasp of the applicable provisions.¹⁴¹ For the most part, the psychiatrists were 'unfamiliar' with the legal criteria and exhibited a general disdain for 'troublesome legalisms'.¹⁴² Indeed, in some cases the participants mistakenly included commitment criteria of their own invention, presumably in much the same way as we saw in the Mersey Care study in part 2.2.2. More recently, Humphreys interviewed seventy-two consultant psychiatrists in Scotland and found that their knowledge of the provisions of the Scottish MHA was limited.¹⁴³ Just over half of the participants in the study were able to give the correct title of the relevant legislation and only one in ten could define 'mental disorder' in the same terms as the statute. Humphreys concluded that mental health professionals might be taking important decisions 'on the basis of a seemingly scant understanding of the law'.¹⁴⁴ Even more concerning was the fact that many of the psychiatrists Humphreys interviewed were either unashamed or unaware of their lack of legal knowledge.¹⁴⁵ Worryingly, he had already observed a similar pattern among junior psychiatrists in a previous study, suggesting

¹⁴¹ G.G. Affleck *et al*, 'Psychiatrists' Familiarity with Legal Statutes Governing Emergency Involuntary Hospitalisation' (1978) 135 *American Journal of Psychiatry* 205, at p207.

¹⁴² *Ibid*, at p209.

¹⁴³ M. Humphreys, 'Consultant Psychiatrists' Knowledge of Mental Health Legislation in Scotland' (1998) 38 *Medicine, Science and the Law* 237.

¹⁴⁴ *Ibid*, at p240.

¹⁴⁵ *Ibid*, at p239.

that there is no connection between a practitioner's experience and his knowledge of the law.¹⁴⁶

The frequency of a decision-maker's deployment of the compulsory powers may, however, have a bearing on how well he knows them. In her survey of 2,022 decision-makers, Peay found that those with key responsibilities under the MHA did not perform as badly when asked about their knowledge of mental health law as previous research might have suggested.¹⁴⁷ Indeed, she found that the psychiatrists and social workers who used the MHA most often had the best knowledge of the law. By contrast, general practitioners, whose interactions with the MHA are much less frequent, fared worse.¹⁴⁸ Peay's study is interesting for two reasons. First, its results are not particularly surprising; it makes sense that those decision-makers who have a greater level of engagement with the commitment criteria should display a more accurate understanding of them. Yet, it was not the case that those who used the MHA the most always had a precise understanding of the law; Peay found that ten *per cent* of the clinicians in her study did not have a full grasp of the criteria for compulsory admission for treatment under section 3 MHA. While the frequency of a practitioner's engagement with the law appears to improve his knowledge of the legal provisions, it does not necessarily follow that his understanding will be any more accurate. Secondly, Peay's study was based on the participants' knowledge of the original 1983 Act, suggesting that a lack of awareness of the law among decision-makers is not limited to other jurisdictions. In many instances a sizeable minority of decision-makers have inadequate or

¹⁴⁶ M.S. Humphreys, 'Junior Psychiatrists and Emergency Compulsory Detention in Scotland' (1994) 17 *International Journal of Law and Psychiatry* 421.

¹⁴⁷ J. Peay, *et al*, 'Legal Knowledge of Mental Health Professionals: Report of a National Survey' (June 2001) *Journal of Mental Health Law* 44, at p52.

¹⁴⁸ *Ibid*.

inaccurate knowledge of the provisions of mental health law. For many practitioners, the legal framework is a non-essential and peripheral consideration which may have no positive bearing at all on their decision-making outcomes.

Peay has made perhaps the most significant contribution to the literature on this point. Her work has highlighted the discrepancy between the notionally prescriptive nature of the English MHA's legal framework and the realities of mental health practice. In her view, this problem stems from the fairly unique way that the MHA seeks to regulate decision-making behaviour.¹⁴⁹ On one hand, the law could comprise an exhaustive list of rules which would seek to achieve substantive justice.¹⁵⁰ On the other, it might confer complete discretion on practitioners and insist only that they comply with the rules of natural justice.¹⁵¹ The MHA, however, strikes a third course which blends these two approaches. This puts the definition of terms critical to the functioning of the compulsory powers within the scope of decision-makers' discretion, i.e., clinicians determine what constitutes mental illness, whether the patient is suffering from one and whether he is affected by it to the requisite degree.¹⁵² As a result, not every aspect of a decision-maker's remit is governed by explicit legal provisions; the MHA sets the limits within which professionals are free to exercise their discretion.¹⁵³

¹⁴⁹ J. Peay, 'The Mental Health Act 1983 (England and Wales): Legal Safeguards in Limbo' (1986) 14 *Law, Medicine and Healthcare* 180.

¹⁵⁰ *Ibid*, at p180.

¹⁵¹ *Ibid*.

¹⁵² Eastman and Peay, *supra* n.139, at p4.

¹⁵³ Ronald Dworkin's metaphor of the ring doughnut is quite apposite here: mental health decision-makers' discretion under the MHA does not exist *except* as an area left open by a surrounding belt of restriction. If the MHA is the doughnut then the hole in the middle is the area in which decision-makers can exercise their discretion. See R. Dworkin, 'The Model of Rules' (1967) 35(1) *University of Chicago Law Review* 14, at p32.

Bynoe and Holland have agreed with this assessment. For them, mental health practice corresponds to the provisions of the MHA in a 'majority' of cases.¹⁵⁴ It cannot achieve perfect alignment because the law is written in such a way as to allow practitioners to use it pragmatically and flexibly. For that reason, it is possible that decision-makers draw on parallel or alternative commitment criteria which do not reflect the contents of the legislation.¹⁵⁵ For Peay, this arrangement means that there is 'plenty of scope for what may appear, from a strictly legalistic perspective, to be bad or illiberal decisions'.¹⁵⁶ In short, the wording of the MHA's provisions may actually undermine the legislation's determinative power.

Nowhere was this clearer than in Peay's study of the dynamics of joint decision-making between psychiatrists and social workers under the original 1983 Act.¹⁵⁷ Using case studies, she asked multiple teams, each comprising two psychiatrists and an ASW, what decisions they would reach if they were examining the patients in the scenarios. Peay found that their knowledge and understanding of the law was poor. Many 'legal' discussions 'were often ill-informed or based on an intuitive understanding' which was not always correct.¹⁵⁸ Practitioners expressed anxiety about the law¹⁵⁹ but typically did not concern themselves

¹⁵⁴ I. Bynoe and A. Holland, 'Law as a Clinical Tool: Practising Within and Outwith the Law' in N. Eastman and J. Peay (eds.) *Law Without Enforcement: Integrating Mental Health and Justice*, Oxford: Hart Publishing Limited, 1999, at p99.

¹⁵⁵ *Ibid*, at p101.

¹⁵⁶ *Ibid*, at p184.

¹⁵⁷ J. Peay, *Decisions and Dilemmas: Working with Mental Health Law*, Oxford: Hart Publishing Ltd, 2003.

¹⁵⁸ *Ibid*, at p29.

¹⁵⁹ *Ibid*, at p159.

with the detail of the legislation. Instead, they would conceptualise what they thought the law did, or ought to, permit them to do and applied that construction.¹⁶⁰ The participants did not therefore adhere to a literal interpretation of the MHA. Moreover, despite their quasi-judicial function, Peay did not find much to suggest that decision-makers carefully weighed the evidence before deploying the compulsory powers.¹⁶¹ Some participants had difficulties with matters of interpretation, for example, they conflated the notions of *conceivability* and *foreseeability*¹⁶² or failed to appreciate the distinction between terms like ‘substantial’ and ‘significant’.¹⁶³ It is perhaps unsurprising then that Peay found that in most cases, the law did not play a determining role in the decisions that the teams reached.¹⁶⁴ It is easy to see why mental health practitioners appear to regard the law as a ‘foreign land’.¹⁶⁵ As Peay explained, it did not seem to matter that the participants had such difficulties; all that seemed to preoccupy their minds was whether they thought that a particular decision was *right* in all the circumstances.¹⁶⁶

¹⁶⁰ *Ibid*, at p167.

¹⁶¹ *Ibid*, at p44.

¹⁶² *Ibid*, at p41. Peay points out that while it may be *conceivable* that she could win £1m on the lottery, it not necessarily *foreseeable*. If decision-makers interpret patients’ risks with reference to what is *conceivable* as opposed to *foreseeable* it follows that they will have a lower threshold for compulsion.

¹⁶³ *Ibid*, at p74.

¹⁶⁴ *Ibid*, at p67.

¹⁶⁵ J. Peay, ‘Decision-making in Mental Health Law: Can Past Experience Predict Future Practice?’ (2005) May *Journal of Mental Health Law* 41, at p51.

¹⁶⁶ *Ibid*.

4.2.2. Decision-makers' application of the law

If decision-makers lack *knowledge* of the MHA's provisions, it follows that they are unlikely to apply the law in the way that Parliament intended. Practitioners may also seek to use the law 'creatively' to generate outcomes which are desirable, if not strictly compliant with the law. A number of studies have shown that decision-makers struggle to apply the law literally. Bean examined compulsory decision-making practices under the MHA 1959.¹⁶⁷ He found that nearly 10 *per cent* of patients ostensibly admitted under the compulsory powers were in fact detained on improper bases. Bean found that decision-makers did not adhere strictly to the 1959 Act when making commitment recommendations. To some extent, this was not especially problematic: there was a 'basic pool' of patients who would *always* be admitted to hospital irrespective of whichever decision-maker signed their section papers.¹⁶⁸ He speculated that two-thirds of all compulsory admissions under the 1959 Act would have occurred regardless, suggesting that decision-makers share a common set of assumptions.¹⁶⁹ This still means that up to a third of all decisions to detain patients could go either way depending on the practitioners involved. In his study, Bean found that the psychiatrist participants admitted twenty-three patients out of fifty eight (39.65 *per cent*) on bases that were contrary to either the letter (i.e., the express wording) or spirit (i.e., the implied policy¹⁷⁰) of the statutory framework.¹⁷¹ The social workers did the same in

¹⁶⁷ P. Bean, *Compulsory Admission to Mental Hospitals*, Chichester: John Wiley and Sons Ltd, 1980.

¹⁶⁸ *Ibid*, at p145.

¹⁶⁹ *Ibid*.

¹⁷⁰ Bean thought that decisions contravened the spirit of the 1959 Act where they were 'linked to areas of personal judgement and to areas which would involve legal arguments about the phraseology used by the Parliamentary draftsman'. *Ibid*.

¹⁷¹ *Ibid*, at p153.

14 cases out of 58; just shy of a quarter (24.1 *per cent*) of their recommendations went beyond the wording or policy of the legislation.¹⁷² Taken together, the proportion of compulsory admissions in Bean's study that occurred contrary to the rules – be they explicit or implicit – reached 53.4 *per cent* of all detentions.¹⁷³ If Bean's work was representative of practice under the 1959 Act, decisions to deploy the compulsory powers were therefore most likely *not* to have been conceived a proper legal basis. To explain this, Bean thought it was possible that many decision-makers enforced rules 'according to demands other than those based on legal requirements'.¹⁷⁴ For that reason, it could not be said that decision-makers took their cues solely from the legislation when deploying the compulsory powers. This means that it is likely that mental health practitioners could justify their decisions to commit patients with reference to factors that had no legal relevance whatsoever.

Later studies have shown that taking extra-legal considerations into account is a fairly common practice. In their study of the civil commitment experiences of 1,226 patients detained in hospital in North Carolina, Hiday and Smith found that the wording of the relevant legislation left so much to be determined by medical opinion that broader extra-legal considerations were implicitly legitimised.¹⁷⁵ In their view, the inclusion of a dangerousness standard in the North Carolinian civil commitment framework necessarily required decision-makers to take factors into account that the legislation did not explicitly endorse. According to Mestrovic and Cook, the dangerousness standard means that the

¹⁷² *Ibid*, at p160.

¹⁷³ *Ibid*, at p177.

¹⁷⁴ *Ibid*, at p151.

¹⁷⁵ V.A. Hiday and L.N. Smith, 'Effects of the Dangerousness Standard in Civil Commitment' (1987) 15 *Journal of Psychiatry and Law* 433.

law's 'traditional' function has become 'saturated with extreme subjectivism', making it difficult to limit the factors that might be relevant to a patient's level of danger in the abstract.¹⁷⁶ For example, major economic forces, such as recession and unemployment, and significant social changes, such as deinstitutionalisation, may have a direct impact on a patient's perceived level of dangerousness.¹⁷⁷ For that reason, the law itself would fail to achieve its purposes if it did not passively legitimise decisions based on a broader reading of its provisions. In another study, Thompson and Ager found that commitment decisions are the result of a blending of legal and non-legal information.¹⁷⁸ They asked 176 psychologists and psychiatrists to make recommendations for or against commitment in a series of vignettes. While the participants quite properly took 'legal' factors like committability, treatability and resources into account, they were also influenced 'by several types of information in addition to the [commitment] criteria'.¹⁷⁹ Similarly, Bagby *et al* asked 495 psychiatrists based in Ontario for their professional views on a number of hypothetical case studies. The researchers found that in 20 *per cent* of the responses decision-makers committed patients who would not meet the legal criteria for compulsory admission in real life.¹⁸⁰ They concluded that there must be other non-legal factors at play in the decision-making process.

¹⁷⁶ S.G. Mestrovic and J.A. Cook, 'The Dangerousness Standard: What is it and How is it Used?' (1986) 8 *International Journal of Law and Psychiatry* 443, at p467.

¹⁷⁷ Hiday and Smith, *supra* n.175, at p450.

¹⁷⁸ J.S. Thompson and J.W. Ager, 'An Experimental Analysis of the Civil Commitment Recommendations of Psychologists and Psychiatrists' (1988) 6(1) *Behavioural Sciences and the Law* 119, at p127.

¹⁷⁹ *Ibid*, at p127.

¹⁸⁰ R.M. Bagby *et al*, 'Decision-making in Psychiatric Civil Commitment: An Experimental Analysis' (1991) 148(1) *American Journal of Psychiatry* 28, at p32.

Peay also found that decisions to detain patients under Part II of the MHA were based on 'innumerable extraneous and irrelevant factors'.¹⁸¹ Consequently, no two cases are the same and no single case is likely to look the same to any two decision-makers.¹⁸² Peay also found that there were many disagreements between the participants in her study, suggesting that the notion that decision-making is consistent in the aggregate may not be accurate.¹⁸³ In fact, it is almost impossible to predict how a given patient might be treated should he be made subject to the compulsory powers. If Peay's findings are representative of mental health decision-making more broadly, the law is plainly not as determinative as one might expect. Indeed, it may passively *encourage* decision-making which is contrary to the policy of the MHA. Peay found that some of the participants in her study made decisions about whether to 'section' a patient first and then justified his commitment afterwards. Such a 'mix-and-match approach' means that there is always a way around the MHA's legalistic prescriptions.¹⁸⁴ This was especially relevant in relation to risk, which Peay thought was 'based on a shifting and malleable factual context'.¹⁸⁵ In her view, the MHA covertly legitimises 'backwards decision-making processes'¹⁸⁶ or '*post-hoc rationalisations*'.¹⁸⁷ Instead of a decision-maker embarking on the sort of fact-finding process we discussed in chapter three, he can make tactical use of the provisions and still comply with the law. In

¹⁸¹ Peay, *supra* n.157, at p18.

¹⁸² Peay, *supra* n.157, at p20.

¹⁸³ Peay, *supra* n.157, at pp16-8.

¹⁸⁴ Peay, *supra* n.157, at p40.

¹⁸⁵ Peay, *supra* n.157, at p46.

¹⁸⁶ Peay, *supra* n.149, at p184.

¹⁸⁷ Peay, *supra* n.157, at p74.

figure 4.8, we can see how this process works; while it does not necessarily comply with the spirit of the MHA, this sort of inverted decision-making does not directly contravene the legislation either:

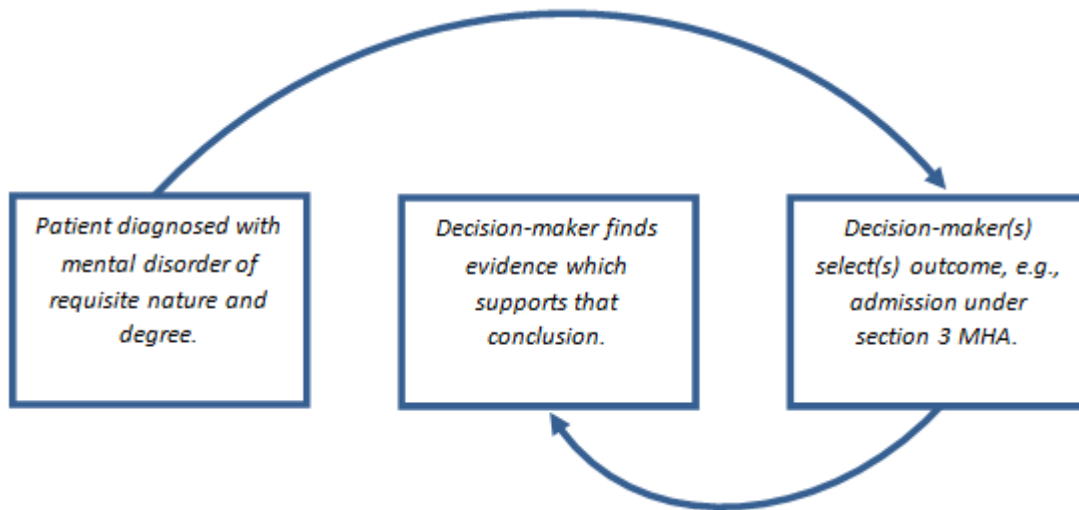


Figure 4.8. Diagram illustrating the mechanics of ‘backwards decision-making’ processes or post-hoc rationalisations.¹⁸⁸

Peay concluded that ‘non-lawyers do not give law the eminence or priority that lawyers do’.¹⁸⁹ Consequently, when the participants in her study reviewed the same factual scenario they often attached their own unique solutions.¹⁹⁰ She compared this phenomenon to the dynamic that exists between friends who see the same film but have differing opinions about its merits. In Peay’s view, legal rules cannot make people see the world in the same way, making the notion that multiple decision-makers will apply the law in the same way seem unrealistic.¹⁹¹

¹⁸⁸ This is adapted from the Mersey Care study, *supra* n.38, at p51.

¹⁸⁹ Peay, *supra* n.157, at p137.

¹⁹⁰ Peay, *supra* n.157, at p164.

¹⁹¹ *Ibid.*

It would be wrong to argue that practitioners' application of mental health law is inevitably an arbitrary process. In their review of the circumstances that had led to the involuntary commitment of 102 patients to a hospital in Ontario, McCready and Merskey found that decision-makers had for the most part practised in accordance with the provisions of the relevant legislation.¹⁹² Of the 102 admissions, the researchers found that ninety-one had met the legal criteria while the other eleven had been based on rather broad, but nevertheless legitimate, interpretations of the law. After interviewing those patients, they found that only one person's commitment to hospital lacked a medical – and, therefore, legal – justification. That McCready and Merskey's data suggest that only one *per cent* of decisions taken under the Ontarian Mental Health Act were illegitimate shows that decision-makers in that particular hospital were typically faithful to the legal rules. Similarly, Appelbaum and Hamm found that the relevant legal criteria were significantly related to discharge decisions taken in Massachusetts.¹⁹³ Interestingly, these criteria included a requirement that decision-makers evaluate patients' level of 'dangerousness'. The researchers studied the responses of thirty-four clinicians to sixty-five requests brought by patients seeking discharge from hospital. In every instance, the participating decision-makers considered factors that were either directly or at least loosely related to the legal criteria. In other words, the participants focused their enquiries on the extent to which a patient could be said to satisfy the dangerousness criterion. Appelbaum and Hamm concluded that the legal criteria 'were among the most important determinants of the

¹⁹² J. McCready and H. Merskey, 'Compliance by Physicians with the 1978 Ontario Mental Health Act' (1981) 124 (March) *Canadian Medical Association Journal* 719, at p724.

¹⁹³ P.S. Appelbaum and R.M. Hamm, 'Decision to Seek Commitment: Psychiatric Decision-making in a Legal Context' (1982) 39(4) *Archives of General Psychiatry* 447.

decision to seek commitment’.¹⁹⁴ These studies from North America suggest that while one can expect some divergence between law on the books and law in practice to occur occasionally, it is by no means inevitable.

The divergence between law and practice is a continuing phenomenon: early indications from the first few years of the DOLS regime suggest that decision-makers have displayed varying degrees of fidelity to the rules that notionally constrain their practices. According to the Care Quality Commission (CQC), there continue to be cases where people who lack capacity are deprived of their liberty without due regard to the DOLS, suggesting that decision-makers are not making use of the applicable legal framework.¹⁹⁵ The Mental Health Alliance has been particularly scathing, describing the DOLS scheme as ‘not fit for purpose’ because of its ‘basic structural flaws’ stemming from the absence of a definition of ‘deprivation of liberty’ and the problems surrounding the interface between the MHA and DOLS.¹⁹⁶ For that reason, the Alliance blamed the lower-than-expected number of applications for standard authorisations on a ‘high degree of misunderstanding and resistance on the part of care providers [and] a poor understanding of the basic MCA.’¹⁹⁷ Practitioners were therefore either ignorant of the legal rules or simply misapplied them. This is a clear example of the way in which the prescriptions of mental health law do not

¹⁹⁴ *Ibid*, at p450.

¹⁹⁵ CQC report, *supra* n.32, at p22.

¹⁹⁶ Mental Health Alliance, *The Deprivation of Liberty Safeguards (DOLS) (pre-publication draft of a chapter from a forthcoming report, 25/11/11)*, at part 2.3. Available at: http://www.mentalhealthlaw.co.uk/images/MH_Alliance_DOLS_report_pre_publication_draft.pdf. Accessed: 11th February 2013.

¹⁹⁷ R. Hargreaves, *Briefing Paper 1 – Deprivation of Liberty Safeguards: an Initial Review of Implementation*, London: Mental Health Alliance, May 2010, at p13. Available at: http://www.mentalhealthalliance.org.uk/resources/DOLS_report_July2010.pdf. Accessed: 11th February 2013.

necessarily translate into practice. Yet this does not mean that mental health decision-makers invariably pay no regard to the law at all. In her work Peay concluded that there was some arbitrariness in mental health decision-making but also recognised that this was inevitable because the law must always operate within a degree of discretion.¹⁹⁸ The CQC's finding that four *per cent* of the 4,576 patient records it inspected in 2011/2012 showed irregularities shows that the law cannot achieve perfection.¹⁹⁹ While a mental health statute will never be an exhaustive map of decision-making practices, it is not the case that practitioners actively ignore it.

4.3. The Verdict

Mental health law does not always map decision-makers' practices. There are two reasons for this. First, mental health practitioners' actual knowledge of the law is imperfect. Several studies have shown that a sizeable minority of decision-makers have a confused or inaccurate understanding the legal provisions that notionally govern their remit. There is no common understanding of the law amongst those people charged with the task of applying it. Secondly, some mental health professionals know the legal rules but still choose to apply them in a way that goes beyond the letter and spirit of the legislation. We have seen evidence that decision-makers take extra-legal considerations into account or make 'creative' use of the legislation in order to achieve a particular outcome. It is plain that the assumptions about the determinative power of the law are flawed.²⁰⁰ As a result of either

¹⁹⁸ Peay, *supra* n.157, at p175.

¹⁹⁹ CQC annual report 2011/12, *supra* n.23, at p15.

²⁰⁰ This is rather topical at the time of writing. The discovery in October 2012 that a 'technical error' had affected approximately 5,000 patients admitted to hospital under the MHA since 2002 demonstrates that policy- and decision-makers do not pay particularly close attention to the law's

confusion or wilfulness, few decision-makers seem to regard the MHA as a definitive statement of the limits of their powers.

We can infer, then, that the 2007 Act is unlikely to have radically altered mental health decision-makers' practices. This seems a particularly reasonable inference to draw in light of the DOLS scheme, which was one of the 2007 Act's innovations but which the evidence suggests decision-makers have engaged inconsistently. Generally, there is no evidence that the practitioners' knowledge and application of the law has changed for better or worse since the amendments of the MHA came into force. The continuation of the steady upward trend in the use of the compulsory powers that started in the mid-1980s suggests that the recent changes in the law have not altered decision-makers' priorities. This means that the same potential for legal uncertainty and decision-making inconsistencies remains. If decision-makers' knowledge of the MHA was weak and their application of its provisions arbitrary before the 2007 Act, the evidence suggests that that is likely also to be the case now. The 2007 Act may merely have retrospectively legitimised decision-making practices which have prevailed long before it came into effect.

5. Conclusions

Three things define the post-2007 Act era. First, record numbers of people with mental disorders were compulsorily admitted to hospital in three out of the four years since the 2007 Act came into force. Secondly, the data show that more patients are detained in hospital at any given time than has ever been the case in the history of civil commitment in

prescriptions. See, BBC News, *Mental Health Sectioning Error*, 29th October 2012. Available at: <http://www.bbc.co.uk/news/health-20126569>. Accessed: 30 October 2012.

England. Thirdly, fewer patients are now subject to informal arrangements outside the scope of the MHA than was the case five years ago. The introduction of the 2007 Act has therefore coincided with an increase in the use of the compulsory powers and a decline in non-MHA care and treatment strategies. If one were to ask whether the post-2007 Act era is characterised by more control and less liberty, the answer is plainly yes.

This tells only part of the story. This chapter has sought to examine whether the *2007 Act* and its *policy emphasis on risk* have led to increased controls over and fewer freedoms for patients with mental disorder; in other words, is there *causation* as well as a *correlation*? Here, the answer is more equivocal. The long-term admission statistics show that the number of compulsory admissions in the post-2007 Act era continues to conform to a trend that began in the mid-1980s. There has been no discernible increase in the *rate* of admissions since the 2007 Act came into force. Consequently, there is no apparent connection between the change in the law and the record number of compulsory admissions. This is despite the broader scope of the MHA's civil commitment criteria and the wider policy emphasis on the importance of the assessment and management of patients' risks. The available empirical evidence also shows that mental health decision-makers were largely unmoved by the 2007 Act's reforms. Most of the participants in the Mersey Care study thought that the post-2007 Act era is characterised by continuity, not change. Their perceptions of risk had not altered at all. This raised important questions about the determinative power of the law over decision-making in the field of mental health.

The rationale for the law's role in mental health practice derives from the assumption that it acts as a definitive prescription of the limits of clinical power. In reality, we have seen

that its role is much less determinative than that. Reforms to mental health statutes do not always achieve their policy objectives and, when they do, their effect is short-lived. Decision-makers' knowledge of the rules that govern their professional responsibilities can lack accuracy and their application of the law can be imprecise. Far from serving as the ultimate authority, the law appears to be one factor out of many that decision-makers may consider – and perhaps even deliberately ignore. When considered against this backdrop, the 2007 Act's apparent failure to accomplish its objectives should not come as a surprise. The law is simply not as determinative as the assumptions about its role might imply.

The 2007 Act is not *directly* responsible for the current situation in which there may now be more control of, and less liberty for, patients with mental disorder. Many of the problems that arise from the divergence between law and practice are long-standing. The problem with the concept of risk discussed in chapter three endures under the 2007 Act. So too do broader issues like the law's failure to complete policy objectives and decision-makers' poor knowledge and application of the rules. There is no evidence that the 2007 Act has exacerbated these problems. By dismantling the original 1983 Act's legalism, the 2007 Act's reforms have retrospectively legitimised established decision-making practices. The law has therefore followed rather than led.

Chapter 5

The Case for New Medicalism: Defending Risk in Mental Health Law

1. Introductory

Conventional wisdom tells us that a mental health statute with broad criteria for detention and an emphasis on risk permits the deployment of coercive power according to a concept that is ill-defined, poorly understood, and inconsistently applied. There is some truth to this: risk is integral to the workings of the Mental Health Act ('MHA') and yet lacks a 'legal' definition. Consequently, the statutory framework notionally confers an unfettered discretion on decision-makers to interpret risks as they see fit, renders it difficult for patients to predict the nature and extent of their interaction with health services, and leaves lawyers questioning the value and utility of legal protections for the mentally ill. When viewed this way, one might conclude that the concept of risk both jeopardises liberty and facilitates control. Yet there is also a compelling case for a statutory framework underpinned by 'New Medicalism', in which the law's determinative power is reduced in order to enhance clinicians' responsiveness to patients' risks. This final substantive chapter defends risk-based laws governing mental health practice.

There can be no doubt that the policy agenda that drove the Mental Health Act 2007 ('2007 Act') sought to loosen the constraints of legalism. The MHA's simpler definition of key terms (i.e., 'mental disorder'¹) and broader commitment criteria (i.e., the 'appropriate

¹ A mental disorder is 'any disorder or disability of the mind', see MHA 1983, s.1(2).

treatment’ test²) were clearly framed in pursuit of that objective. The amended MHA therefore appears to facilitate control. If the conventional wisdom holds true, this New Medicalist paradigm should have led to greater uncertainty for patients and inconsistency among decision-makers. In short, the 2007 Act will also have jeopardised liberty. Yet, surprisingly, no such evidence exists. The amendments to the MHA are likely to have made little, if any, practical difference. Although the 2007 Act certainly has the *potential* to jeopardise liberty, mental health practitioners responded to the MHA’s amendments by carrying on as usual. This weakens the argument that Parliament should tighten the provisions of the MHA – why would this be necessary if decision-makers appear to be not overly constrained by the law in any event? If anything, the framework is now aligned to decision-makers’ pre-existing practices rather than the other way round. Any threats to liberty or increases in controls may therefore be attributable to factors quite separate from the 2007 Act.

This final substantive chapter will argue that New Medicalism may have some merit as a policy basis for mental health law. It is not a self-evident truth that risk-based mental health laws are inferior to those rooted in capacity, nor is it axiomatic that legalism is a more desirable underpinning than a philosophy which enhances professional discretion. This chapter will explore the two fundamental reasons for this. First, risk-based laws offer a realistic and pragmatic answer to the challenges of mental health practice. The concept of risk is a useful (though imperfect) device which reflects the vicissitudes of mental health decision-making. Secondly, mental health professionals are ‘experts’ in risk. This chapter will draw on the work of Michael Polanyi to argue that decision-makers possess *tacit knowledge*

² MHA 1983, s.3(2)(d).

of patients' risks which defies objective explication. It is therefore neither possible nor desirable for a statutory framework to define 'risk' with sufficient accuracy to guarantee certain and consistent outcomes in every case.

This chapter seeks to make an original contribution to the field of mental health law and policy. It will raise arguments that will serve as a counterblast to the prevailing wisdom. There may be much to criticise in the 2007 Act but this thesis suggests that the impact of its reforms has been negligible. More research may be required to corroborate and develop these findings, but the arguments in this chapter may give policy-makers a reason to reflect before embarking on more radical reforms in the future.

2. Realistic and Pragmatic: the Case for New Medicalism

2.1. Defining 'New Medicalism'

There has long been a tension between 'legalism' and 'medicalism' in mental health law. At the root of the conflict between these competing philosophies is the extent to which the law should play a determinative role in mental health decision-making. Should it prescribe the limits of clinical power or should it facilitate the exercise of professionals' discretion? As we saw in chapter four, the upshot of this controversy may be moot: the determinative potential of mental health law is overstated. In any event, prior to the 1983 Act, whether a statute was legalistic or medicalistic was nothing more than an interesting philosophical question. More recently, the consequences for patients of this philosophical tension have grown in significance. We know that Unsworth coined the term 'New Legalism'³ to describe the character of the original 1983 Act because it represented a different kind of legalism

³ C. Unsworth, *The Politics of Mental Health Legislation*, Oxford: Clarendon Press, 1987, at p342.

from that which informed, for example, the Lunacy Act 1890, which provided a legal basis to distinguish 'lunatics' from the rest of the population. This newer brand of legalism goes much further by extending legal protections to those people actually falling *within* the ambit of the civil commitment powers. For the first time, the drafting of a mental health statute had regard to patients' interests; they enjoyed explicit protection from arbitrary or unnecessary admissions to hospital and were granted a degree of self-determination in key treatment decisions. This undoubtedly had profound consequences for patients' experiences of compulsory care and treatment.

If the 1983 Act heralded a new kind of legalism then it is submitted that the 2007 Act has done the same for medicalism, with equally far-reaching consequences. The 2007 Act embodies the distinct philosophy of 'New Medicalism', which represents a fresh take on the conventional understanding of the medicalist approach. While 'medicalism' will always convey a preference for professionals' discretion over legal prescriptions, the objectives of its proponents can vary. The Mental Health Act 1959 was the high-water mark of what might be described as 'conventional' medicalism. It sought to divest mental health law of at least some of its legalistic prescriptions to reduce the law's constraining influence. The rationale for this was to allow decision-makers to practise more freely than the law would allow and thereby work to improve health outcomes. Two things are implicit here. First, the law is not necessarily an effective means of improving health outcomes. Mental health legislation carries no therapeutic benefit in itself. Secondly, clinicians and other mental health professionals are in the best position to diagnose, care for and treat patients with disorders or disabilities of the mind. The law is no substitute for this professional expertise. Its role should therefore be restricted to providing a predictable framework of rules; it

should not play any part in fettering decision-makers' professional discretion. While lawyers might instinctively balk at the suggestion that law is not always the answer, the case for conventional medicalism was based on a sound logical footing by recognising the limits of statutory intervention.

The 2007 Act's objectives, by contrast, are markedly different from those associated with conventional medicalism. While it is true that the 2007 Act possesses a medicalistic character, its dismantling of legalistic obstacles was not primarily motivated by the desire to improve patients' health outcomes. Instead, its emphasis is on reducing the determinative power of the law in order to give decision-makers a freer hand to respond to the risks posed by mentally disordered patients to themselves or other people. New Medicalism therefore co-opts mental health professionals into functioning as part of a regulatory regime designed to protect patients and the public from risk. Although this may seem to imply cynicism, it should be stated that it does not necessarily follow that mental health practice conducted with reference to risk de-prioritises concerns about patients' health. Indeed, it will be a core argument of this chapter that considerations of health and risk go hand-in-hand. Nonetheless, the policy drivers behind the 2007 Act were distinctive: while New Legalism reinforced patients' rights, New Medicalism recast mental health decision-makers as regulators of risk. In *figure 5.1*, we can see where New Medicalism sits in the philosophical palette:

Legalism A patient may only be admitted to hospital if he/she satisfies the relevant legal criteria. The governing statute provides a fixed legal basis for detention and may also feature some kind of judicial supervision of the admissions procedure. This philosophy is more concerned with protecting members of the public from arbitrary or unnecessary admission to hospital than defending the rights of the mentally ill. See, e.g., the Lunacy Act 1890.	Medicalism A patient may be admitted to hospital where the relevant mental health professionals deem it necessary. The governing statute confers a degree of discretion on practitioners to decide who should be admitted to hospital in accordance with their training and expertise and in the interests of achieving positive health outcomes for patients with mental disorders. There is no judicial oversight of the admissions process, which tends to be administrative in nature. See, e.g., the Mental Health Act 1959.
New Legalism The ‘libertarian’ analogue of legalism. A patient’s admission is still determined with reference to fixed legal criteria, but the governing statute also extends rights to patients which enable them to challenge the basis for their continuing detention in hospital. The governing statute may also mandate that the patient’s consent or best interests be taken into account before certain irreversible or hazardous medical treatments can be administered. See, e.g., the original Mental Health Act 1983.	New Medicalism The governing statute reduces the determinative power of the law and confers a degree of discretion on decision-makers. In this instance, mental health professionals act as regulators of the risks that patients with mental disorder can pose to themselves or others. The governing statute thereby functions as a regulatory regime for risk. Mental health services must achieve or at least facilitate positive health outcomes as an incidental effect. The use of the concept of risk in conjunction with broad commitment criteria keeps opportunities for judicial oversight to a minimum. See, e.g., the Mental Health Act 2007.

Figure 5.1. A table comparing the various philosophical underpinnings of mental health law and policy.

At first glance, New Medicalism does not have much to recommend it from a legal point of view. First, it deliberately diminishes the law’s substantive and procedural protections, leaving patients at the mercy of decision-makers’ varying assessments of their risk profile and therefore in a continuing state of uncertainty. For lawyers preferring a clear and unambiguous framework this arrangement is likely to be wholly unsatisfactory. Secondly, it insists on the interpretation of mental health matters through the prism of risk, rendering the engagement of the compulsory powers wholly contingent on the patient being deemed

to be likely to cause harm to himself or other people. This is despite the fact that the concept of risk lacks any legal definition or description which might promote consistency. A mental health statute imbued with the spirit of New Medicalism therefore might appear to have very little to do with 'health' at all. While these criticisms are valid, New Medicalism may offer some realistic and pragmatic solutions to problems which often solicit no easy answer.

2.2. The Certainty of Uncertainty

Decisions relating to the care and treatment of people suffering from mental disorders are taken against a backdrop of inevitable uncertainty. At the heart of mental health practice is a conflict between these uncertainties on one hand and the statutory provisions which rarely make allowances for them on the other. A particular mental illness or disorder may manifest itself in a number of different ways, making it difficult for clinicians to diagnose patients according to preconceived notions of a 'classic' symptomatology. There may be no such thing as a 'textbook' case of schizophrenia or depression; patients with these diagnoses are likely to find themselves placed on a continuum of illness. This means that two patients may notionally have the same mental illness but their condition may manifest itself in different ways. Such variation poses a challenge to practitioners seeking to ensure a patient 'fits' the admission criteria at the gateway to the compulsory powers. Similarly, some patients may pose risks to themselves or other people which warrant coercive intervention, but not every disorder leads a person to commit self-harm, suicide or violence against others and not every risk implies mental illness. To make matters even more complicated, few mental disorders are amenable to the sort of objective clinical testing that can help doctors to diagnose physical illnesses. While testing for physical

conditions like diabetes or high blood pressure is common and straightforward, there is no equivalent procedure which can help to diagnose a mental disorder like schizophrenia with the same degree of accuracy. Similarly, there is rarely a 'magic bullet' which will cure every case of a particular mental disorder in the same way that antibiotics are effective against certain bacterial infections, for example. Treatments for some mental disorders appear to rely on a process of trial and error as opposed to decision-makers' understanding of how the conditions might respond to particular drugs or therapies. Uncertainty is therefore an inevitable part of mental health decision-making; aligning fixed legal standards with the fluid realities of practice was always going to be difficult. It should come as no surprise at all that legalistic mental health statutes have usually failed to achieve their policy objectives given that they have sought to demand certainty from an intrinsically uncertain field.

New Medicalism as we conceive it implicitly recognises this fact. It accepts that the law's influence on mental health practice is weak and consequently downplays its significance. Instead of tight legal prescriptions, New Medicalism imposes a looser belt of statutory control within which decision-makers can enjoy a broader discretion to determine whether a patient should be admitted to hospital or not. Although it entails a revival of conventional medicalism, there is a clear distinction between the 1959 Act, which extended clinicians' discretion in the interests of improving health outcomes, and the 2007 Act, which might be said to acknowledge the limits of legalism. The 2007 Act's principal reforms clearly signify the abandoning of the pretence that comprehensive legal criteria are a necessary feature of a mental health statute. Instead, the amendments have conferred broader discretion on decision-makers to determine how their patients should interact with mental health services. In this way it is perhaps the most honest philosophy on which mental health law could be based; it acknowledges the limits of the law's reach and tries to work within them.

It accepts in a way that the various strands of legalism never could that mental health practice is an uncertain phenomenon and that the law can do very little to rectify this. In other words, New Medicalism caters for the uncertainties inherent in mental health practice. Throughout this thesis, we have asked whether the 2007 Act has led to uncertainty among practitioners and patients. The answer is plainly no: there has *always* been uncertainty when it comes to mental health decision-making. For the first time, however, it appears that a mental health statute is rooted in a philosophy which accommodates that fact.

2.3. The Benefits of Risk

A mental health statute preoccupied with risk has a reductive tendency which transforms autonomous service-users into crude entities defined by their potential to cause harm to themselves or other people. When viewed in this way there is no doubt that New Medicalism is fundamentally about social control. Yet risk has many virtues which would appear to contradict this conclusion: a risk-based mental health statute may actually be an effective way to administer compulsory care and treatment. There are several reasons for this. It is worth exploring them in some detail.

2.3.1. Historical Invariance

Risk has been an enduring theme of mental health legislation throughout history. This suggests that the concept serves a purpose which cannot be discounted lightly. While the actual word 'risk' only appeared for the first time in the 2007 Act's provisions, we saw in chapter one that successive statutory regimes have employed the same or similar 'risk formula' which appears in the current MHA. It has always been heavily implied that the

chance that a mentally disordered person might upset the social norm in some way justifies coercive steps by clinicians or judges to prevent that from occurring. The idea that compulsory interventions are contingent on a patient's health or safety or the need to protect the public is therefore nothing new. It has always been the *raison d'être* of mental health statutes to protect things like property rights, the social order and public safety by reducing or extinguishing the risks that people suffering from 'conditions' like lunacy, feeble-mindedness, and mental disorder may pose. Law-makers have apparently valued the concept's significance to the law's protective function in this field throughout successive periods of reform; indeed, they have actively sought to retain its role in the law's mechanics. This point is particularly compelling when one recalls how prone to change mental health law has been since the Victorian era. Parliament has introduced a new statutory regime approximately every quarter of a century since 1890.⁴ While law-makers have had plenty of opportunities to abandon risk as a component of mental health decision-making, they have actively retained its role at the heart of the legislative framework. It is reasonable to infer from this that the concept possesses some value in accomplishing the policy objectives of mental health law.

The fact that risk was the principal policy driver of the 2007 Act is not at all extraordinary. Nor is it especially controversial that its reforms were justified on the grounds of public protection:⁵ there is nothing new about social control being a theme of mental

⁴ To be precise, the average period between each new statute is 23.4 years. The longest period between statutes is twenty-nine years, which elapsed between the introduction of the Mental Treatment Act 1930 and the enactment of the Mental Health Act 1959. The shortest period was seventeen years, which separated the Mental Deficiency Act 1913 and Mental Treatment Act 1930. At this rate, we should not expect a new Mental Health Act until 2030.

⁵ The Secretary of State is now under a specific duty to address the matter of public safety when drafting a statement of principles to be included in the Code of Practice. See, MHA 1983, s.118(2B)(i).

health law. As Bartlett rightly points out, the only way to abolish the social control function of psychiatry would be to prohibit psychiatric treatment 'on any but competent and freely consenting patients.'⁶ Given that no mental health statute has ever mandated such an approach, it appears that the themes of public protection and social control have long shaped the law in this area. Indeed, Walker argues that the protection of the public is no less valid a justification for coercive mental health legislation than the need to administer medical treatment.⁷ In his view, it is morally defensible to detain or control certain people for the protection of others and it is not impossible for the law to contain satisfactory safeguards which give effect to that objective.⁸ We must therefore regard the 2007 Act as simply the latest in a long line of statutes whose underlying policies have sought to find some way of achieving the legitimate aim of managing and controlling the risks posed by people suffering from mental disorders. To describe the post-2007 Act era as an 'age of risk' as though it constitutes some great departure massively overstates the impact that the legislation has had. It is simply not true that the amendments introduced by the 2007 Act are fundamentally distinct: the 'risk formula' that appeared in the original 1983 Act continues to apply. It is certainly arguable that the 2007 Act did not intend to make *any* significant changes to the way that risk is assessed and understood by clinicians: it did not amend the risk formula, gloss any of the compulsory admission criteria, or mandate the use of specific risk assessment tools. While New Medicalism certainly put risk at the heart of mental health *policy*, its impact on the law since is not immediately obvious.

⁶ P. Bartlett, 'The Test of Compulsion in Mental Health Law: Capacity, Therapeutic Benefits and Dangerousness as Possible Criteria' (2003) 11 *Medical Law Review* 326, at p329.

⁷ N.D. Walker, 'Protecting People' in J.W. Hinton (ed.) *Dangerousness: Problems of Assessment and Prediction*, London: George Allen and Unwin, 1983, at p26.

⁸ *Ibid.*

Although it is not the case that something is indisputably a good thing because it has been around for a long time, the fact that risk has endured as an implicit theme of mental health law for so long suggests that Parliament has recognised the concept's utility. There may therefore be a consensus that no alternative device exists which might better govern the deployment of the compulsory powers. Risk's endurance hints at its effectiveness.

2.3.2. Tailored Responses

Some people with mental disorders will harm themselves or others. The consequences of this can be tragic. More prosaically, some people with mental disorders will be at risk of having their condition deteriorate if they do not receive medical care or treatment. Decision-makers must be alert to these risks in order to prevent or minimise harm to the patient and other people. If they were not sensitive to these signals then practitioners would presumably view all patients with mental disorders in the same way, i.e., as equally needful of compulsory care and treatment. It surely must not be the case that anyone with a mental disorder should be equally liable to coercion under the MHA.

As we have seen, the MHA provides a framework through which decision-makers can administer compulsory care and treatment to people with mental disorders *of the requisite nature or degree*.⁹ It follows that Parliament did not intend to create a comprehensive statutory regime whose provisions would apply in the same way to every person suffering from a mental disorder. The MHA is designed to be a measure of last resort that forms part of a broader palette of clinical strategies. It is not the case that merely suffering from a mental disorder is a sufficient condition to engage the MHA. In theory, decision-makers

⁹ This wording appears throughout the MHA to distinguish those patients to which its provisions apply from those to whom they do not. See, MHA 1983, ss.2(2)(a), 3(2)(a), 7(2)(a), 17A(5)(a), 20(4)(a), 20(7)(a), 20A(6)(a), 72(1)(a)(i), 72(1)(b)(i), and 72(1)(c)(i).

should consider caring for or treating their patients on a voluntary or informal basis outside the ambit of the MHA before escalating to the compulsory powers. This is clearly consistent with the fundamental principles of proportionality and least restriction,¹⁰ which dictate that decision-makers should go no further than is necessary to achieve a legitimate aim. These principles have since been incorporated into the MHA Code of Practice,¹¹ meaning that clinicians and allied professionals should have regard to them when caring for and treating their patients. The upshot is that the compulsory powers are not a blunt instrument – their deployment must be commensurate with a patient’s mental disorder. There must therefore be some way of determining whether compulsory admission is indicated. The concept of risk offers an effective tool with which decision-makers can make this determination. By evaluating a patient’s risk, mental health practitioners can *tailor* their responses to his condition. In this way, mental health laws which incorporate risk are highly responsive to each patient’s immediate care and treatment needs.

According to Alaszewski, the advantage of taking healthcare decisions with reference to risk is that clinicians can narrow the focus of their interventions and thereby practise according to the priorities of a harm reduction model.¹² Risk-based practices implicitly accept that curing a person of whatever mental health condition or disorder affects him can be a protracted and indeterminate process. The aim is instead to stabilise the patient and lessen the chance of adverse incidents, thereby allowing practitioners to manage his restoration to health. There are therefore no preconceived notions of ‘desirable’ behaviours

¹⁰ MHA 1983, s.118(2B)(c).

¹¹ Department of Health, *Code of Practice: Mental Health Act 1983*, London: TSO, 2008, at para.1.3.

¹² A. Alaszewski, ‘Health and Welfare: Managing Risk in Late Modern Society’ in A. Alaszewski *et al* (eds.) *Risk, Health and Welfare: Policies, Strategies and Practice*, Buckingham: Open University Press, 1998, at p142.

which should be maintained at all costs and there is no automatic tendency towards compulsory intervention.¹³ Decision-makers intervene where a patient's vulnerability or potential to cause harm exceed a particular threshold. The inference one can draw from a decision to engage the MHA's compulsory powers is that the disorder of the person subject to them is no longer amenable to voluntary or informal arrangements. It does not mean that those subject to the MHA are mentally ill while those outside its ambit are not. Consequently, the law recognises that a person's mental health status is not evaluated in binary terms. The concept of risk is a useful device which allows decision-makers to mount nuanced and considered responses to their patients' needs. When viewed in this way, the concept actually works in a patient's interests by ensuring that his interaction with mental health services remains a highly personalised experience commensurate with his risk profile.

2.3.3. The Lack of a Credible Alternative

In spite of the criticism that risk-based mental health legislation receives, there are no other equally credible mechanisms on which to justify compulsory care and treatment for people with mental disorders. Even if Parliament were to adopt the alternative of a capacity-based framework, it would be unlikely to render the concept of risk redundant. Indeed, authorising civil commitment on the basis of a patient's capacity may in fact be wholly ineffective because it does nothing to achieve the legitimate objective of protecting the public and the patient from harm.

Since the Mental Capacity Act (MCA) 2005 came into force, a person is deemed to lack capacity in relation to a matter if, at the material time, he is unable to make a decision relating to it for himself because of an impairment of, or a disturbance in the functioning of,

¹³ *Ibid.*

his mind or brain.¹⁴ That person will be deemed unable to make a decision if he is unable to (a) understand the information relevant to the decision, (b) retain that information, (c) use or weigh that information as part of the process of making a decision, or (d) communicate his decision.¹⁵ If a person cannot make such a decision, his clinical team may then act in accordance with an assessment of his 'best interests'.¹⁶ In every case, a person is presumed to have capacity unless it is established that he lacks it.¹⁷ This means that a person suffering from a mental disorder (i.e., any disorder or disability of the mind¹⁸) is not necessarily also lacking capacity for the purposes of the MCA 2005.¹⁹ Were this approach to be incorporated into the MHA's civil commitment framework in place of the risk formula, the deployment of the compulsory powers would be contingent on either (i) a patient with capacity consenting to his admission to hospital, or (ii) a patient lacking capacity being admitted to hospital in accordance with the relevant decision-makers' assessments of his 'best interests'.

At first glance, one might assume that capacity is a more 'progressive' legal basis on which to deploy the compulsory powers. There are two reasons for this. First, it collapses the distinction between physical and mental illnesses. In the same way that a doctor can only give a patient medical treatment for a physical condition where he consents (which

¹⁴ Mental Capacity Act 2005, s.2(1).

¹⁵ Mental Capacity Act 2005, s.3(1).

¹⁶ Mental Capacity Act 2005, s.4. For further discussion on what 'best interests' assessments might entail, see also Re MB (Medical Treatment) [1997] 2 FLR 426; Re A (Male Sterilisation) [2000] 1 FLR 549, *per* Butler-Sloss LJ; Trust A v H (An Adult Patient) [2006] 9 CCLR 474.

¹⁷ Mental Capacity Act 2005, s.1(2).

¹⁸ MHA 1983, s.1(2) (as amended).

¹⁹ This distinction predates the Mental Capacity Act 2005. See, e.g., Re C (Adult: Refusal of Medical Treatment) [1994] 1 WLR 290, *per* Thorpe J; Re MB (An Adult: Medical Treatment) [1997] 2 FCR 541, *per* Butler-Sloss LJ. C.f., R v Ashworth Hospital Authority, ex parte Brady [2000] Lloyd's Rep Med 355.

means, *a fortiori*, that he also has capacity to give such consent), a psychiatrist could only admit or treat a mentally disordered patient if he consented (thereby making use of his capacity) to such a course of action. In the case of both physical *and* mental disorders, then, if the patient were found to lack capacity his doctors could take the relevant decisions in accordance with his best interests. Secondly, an impaired decision-making test would ensure that clinicians' focus is fixed on their patients' interests rather than on the potentially prejudicial exigencies of public protection. Compared with the mechanics of the current MHA, one might conclude that this is a more logically defensible framework than one which insists on a spurious distinction between physical and mental disorders and incorporates social control into clinicians' competences.

Yet, the consequence of making compulsion contingent on capacity is an absurdity in which a patient suffering from a serious mental disorder could effectively be placed beyond the reach of mental health services where his ability to take decisions remains unimpaired. This would undoubtedly undermine the justification for civil commitment as a protective mechanism: why would coercive legislation be necessary at all if clinicians could only administer care and treatment following the patient's consent or according to his best interests?

Let us consider a hypothetical person, 'Jim', who suffers from clinical depression. As a result of his mental disorder, Jim exhibits a tendency to self-harm, fantasises about killing himself and expresses a credible intention to do so should he find the opportunity and means. Under the sort of risk-based framework which exists under the current MHA, Jim's clinical team would, at the very least, conclude that he (a) is suffering from a mental disorder of the requisite nature or degree which warrants assessment in hospital, and (b)

ought to be detained in the interests of his own health or safety.²⁰ If the relevant mental health services are familiar with Jim's case, they may decide to skip the assessment process and recommend his compulsory admission for treatment.²¹ In any event, Jim would be admitted to hospital on a compulsory basis because of the risk that he is perceived to pose to himself. If Jim's capacity were the determining consideration, however, the decision to deploy the compulsory powers would be less straightforward. Importantly, Jim can understand the information given to him by his clinical team, can retain and use it in the process of making a decision, and is able to communicate that decision to his doctors. He therefore has capacity. Jim knows that suicide ideation is a symptom of his mental illness but he wants to kill himself in order to put an end to his misery. He has reached that decision of his own accord and by exercising his full capacity. For that reason, Jim declines medical treatment and refuses to consent to his admission to hospital. Jim would therefore presumably be beyond the reach of the capacity-based compulsory powers. It is fundamental to the MCA 2005 that a person is not to be regarded as lacking capacity merely because he has made an unwise decision.²² Any attempt to get around this by using some intellectual sleight of hand which reinterprets suicide ideation as self-evidently probative of Jim's lacking capacity would be pure sophistry. Jim's clinical team would therefore be powerless to treat his depression and thereby prevent his suicide.

This poses something of a dilemma. On one hand, it is established law that an adult patient with capacity may refuse to consent to medical treatment, even where he may die

²⁰ MHA 1983, s.2(2).

²¹ MHA 1983, s.3.

²² Mental Capacity Act 2005, s.1(4).

as a consequence of this refusal.²³ On the other hand, it seems absurd that the law should allow mental health practitioners to stand aside and do nothing to prevent patients causing harm to themselves or other people. The law's libertarianism stems from the fundamental principle of autonomy which forms the bedrock of contemporary medical law and ethics.²⁴ It also seeks to protect the patient from the infliction of unlawful force by another person.²⁵ If we accept the argument that there is little essential difference between a patient refusing medical treatment for a physical disorder and one declining treatment for a mental illness, it follows that Jim's clinical team must respect his refusal to consent to his admission to hospital or medical treatment. This means that Jim's clinical team could do nothing to stop him from killing himself.

Divest the MHA of risk and we are left with a statutory framework that is powerless to prevent the sort of harm that justifies its existence. Bartlett recognised this problem in the midst of the controversy about replacing the MHA 1983, arguing that it would be difficult to countenance a result in which a purportedly dangerous person with mental illness could remain untreated and uncontrolled because he happened to retain capacity and refused any medical interventions.²⁶ He suggested that capacity should be relevant to a patient's *treatment* after his admission to hospital, rather than his initial detention in the first place.²⁷ Even in those circumstances, however, a patient could be held in hospital and still not

²³ See, e.g., Airedale NHS Trust v Bland [1993] 1 All ER 821, HL; St George's Healthcare NHS Trust v S [1999] Fam 26, CA; Re C (adult: refusal of treatment) [1994] 1 WLR 290; Re AK (Adult Patient) (Medical Treatment: Consent) [2001] 1 FLR 129.

²⁴ See, T.L. Beauchamp and J.F. Childress, *Principles of Biomedical Ethics*, 6th ed., Oxford: OUP, 2009, chapter 4.

²⁵ Collins v Wilcock [1984] 3 All ER 374.

²⁶ Bartlett, *supra* n.6, at p341.

²⁷ *Ibid*, at p333.

receive treatment for his mental disorder because he has refused to consent to it. This would raise the prospect of a form of preventive detention which surely runs contrary to the spirit of using the patient's capacity as the key trigger to compulsion. Other commentators have sought to sidestep this problem by proposing a more complex formulation of capacity based on the interplay between a person's cognition, emotion and volition.²⁸ This would further complicate mental health practitioners' task of determining whether compulsory admission is indicated. In any event, leaving aside the issue of the mechanics of a capacity-based framework, there are two reasons why such an arrangement is wholly unsatisfactory. First, it seems perverse that psychiatrists should be able to stand back and allow a person with a debilitating mental disorder to kill himself. While Jim might retain his capacity, his mental disorder has undoubtedly left him in a vulnerable position. It could be argued that a capacity-based framework would require doctors to breach the duties they owe to their patients, which surely offends both legal principle and professional ethics.²⁹ Indeed, if the law exists – *inter alia* – to protect vulnerable people,³⁰ it would contradict its essential purpose if patients like Jim were allowed to kill themselves. This is a humanitarian argument which takes account of our instinctive revulsion to the notion that such a preventable thing should be allowed to happen. There seems to be an intuitive difference between the way

²⁸ C. Heginbotham and M. Kinton, 'Developing a Capacity Test for Compulsion under Mental Health Law' (2007) May *Journal of Mental Health Law* 72, at p78.

²⁹ The House of Lords considered a strikingly similar point in Reeves v Commissioner of Police for the Metropolis [1999] 3 WLR 363, in which a prisoner, who was a known suicide risk, hanged himself whilst in custody. The defendants accepted that they owed the prisoner a duty of care but argued that his suicide broke the chain of causation. Their Lordships rejected this submission: Lord Hoffman said, at 367, that it would be nonsense 'if the law were to hold that the occurrence of the very act which ought to have been prevented negated the causal connection between the breach of duty and the loss.'

³⁰ See, e.g., R (On the Application of Pretty) v Director of Public Prosecutions (Secretary of State for the Home Department intervening) [2001] UKHL 61.

we might regard a patient who refuses treatment for cancer knowing that he will surely die without it and a patient who refuses treatment for a mental disorder which is causing him to idealise suicide. In the former case, the patient has exercised his right to self-determination to take a decision which may shorten his life. In the latter, the patient is suffering from a mental disorder which has affected his thought processes. A patient with such a mental disorder cannot really be in a position to exercise his right to self-determination; indeed, compulsory treatment in Jim's case may actually be the only way to stabilise his condition and thereby *restore his autonomy*. For that reason, allowing mental health practitioners to intervene in such cases seems both pragmatic and compassionate.

Secondly, it would seem rather incongruous if the law did nothing to prevent the risks of harm to other people which arise as a result of someone's mental illness. If a patient suffering psychotic symptoms and known to mental health services issues specific threats to do violence to another person then it is surely within the interests of the wider community for his self-determination to be overridden? This must apply even where the patient has capacity and duly refuses to consent to admission to hospital. Variations on this communitarian argument have justified the suspension of the usual legal principles in cases where people with mental disorders have been deemed to pose a risk to other people.³¹ It is submitted that some mental health matters can have a bearing on the wider community in a way that makes them wholly distinct from most physical illnesses. While there may be some

³¹ See, e.g., W v Egdell [1990] Ch 359, where the Court of Appeal held that the public interest in the maintenance of a doctor's duty of confidence to his patient must be weighed against the public interest in protecting others from possible violence. Where the latter outweighs the former, a doctor may breach his patient's confidentiality in the interests of public safety. See also the Californian case Tarasoff v Regents of the University of California 551 P.2d 334 (1976), where it was held that a psychologist was under a duty to breach confidentiality where his patient declared his intention to kill a specific individual. These cases contain echoes of the notion of 'distributive justice', referred to by Lord Steyn in McFarlane v Tayside Health Board [1999] 3 WLR 1301, at 83.

intellectual satisfaction to be gained from collapsing this distinction, it is submitted that the quest for such logical purity may in fact create newer and more intractable problems. The distinction between physical and mental disorders serves a vital purpose in justifying the different ways in which doctors treat them. A statutory framework which incorporates the concept of risk authorises decision-makers to deploy the compulsory powers in order to prevent or minimise adverse incidents for the benefit of patients and the community. By contrast, a civil commitment regime based on patients' capacity carries no protective function and serves little purpose. It is therefore submitted that risk is an irreplaceable and inevitable feature of any statutory framework.

The authors of the Richardson expert committee report apparently recognised this point. It will be recalled that they proposed a new statutory framework to replace the MHA 1983. Crucially, capacity was indeed 'central' to the Richardson Committee's recommendations,³² but the report's authors *retained the risk formula in its proposed admission criteria*. In fact, Richardson's recommendations would have done nothing to weaken risk as the key trigger to compulsion; capacity was merely an additional consideration in the proposed framework. It is simply not true that had Parliament adopted Richardson's recommendations it would have led to radically different compulsory admission criteria from those which apply in the post-2007 Act era. Take admission for assessment. To be admitted on this basis under the Richardson framework, the relevant decision-makers would have required objective grounds to believe four key criteria. First, the patient would have to have been suffering from a mental disorder requiring care and treatment under the supervision of specialist mental health services. Secondly, *in the*

³² Department of Health, *Report of the Expert Committee: Review of the Mental Health Act 1983*, November 1999, at para.5.102.

interests of the patient's health or safety or for the protection of others from serious harm or for the protection of the patient from serious exploitation, the mental disorder would have required assessment.³³ Thirdly, either (i) the patient would have to have lacked capacity to consent to care and treatment for mental disorder, or (ii) if the patient had capacity to consent to the proposed care and treatment, there would have to have been *a substantial risk of serious harm to the health or safety of the patient or to the safety of other persons* if he remained untreated, and there would have to have been positive clinical measures included within the proposed care and treatment plans which would have been likely to prevent deterioration or secure an improvement in the patient's mental condition.³⁴ Fourthly, an adequate assessment could not have been conducted in the absence of compulsion.³⁵ The striking thing about these criteria is that while they would certainly have made the patient's capacity a relevant consideration in the decision-making process, they would not have challenged the primacy of risk as the fulcrum on which the compulsory powers turn. Not only does a variation on the risk formula continue to apply, but a 'substantial risk of serious harm to the health or safety of the patient or to the safety of other persons' would effectively overrule a refusal to consent *by a patient with full capacity*. Richardson's recommendations therefore put capacity in a subordinate position to risk. This would have applied equally in the case of the proposed 'compulsory order', which would have been a longer-term legal instrument authorising detention in hospital for treatment lasting for up to six months in the first instance.³⁶ In order to obtain a compulsory order, the

³³ Emphasis added.

³⁴ Emphasis added.

³⁵ Richardson committee, *supra* n.32, at para.5.18.

³⁶ *Ibid*, at para.5.85.

patient's clinical team would have had to apply to a special tribunal, which would have determined whether the relevant criteria were satisfied. First, the patient would have to have been suffering from a mental disorder of such seriousness that he would require care and treatment under the supervision of specialist mental health services. Secondly, the proposed care and treatment would have to have been the least restrictive and invasive available. Thirdly, the proposed care and treatment would have to have been in the patient's best interests. Finally, if the patient lacked capacity to consent to care and treatment, a compulsory order would have to have been *necessary for the health or safety of the patient or for the protection of others from serious harm or for the protection of the patient from serious exploitation*³⁷ and the only means of delivering the proposed care and treatment without compulsion. Alternatively, if the patient had capacity to consent to the proposed care and treatment then his refusal to consent could have been overruled where there was *a substantial risk of serious harm to the health or safety of the patient or to the safety of other persons if he were to remain untreated*³⁸ and there would have to have been positive clinical measures included within the proposed care and treatment which would be likely to prevent deterioration or to secure an improvement in the patient's mental condition.³⁹

The Mental Health (Care and Treatment) (Scotland) Act 2003 comprises a similar framework to that which Richardson had proposed in 1999. The provisions governing short and long-term detention in hospital require a patient with mental disorder to pose some level of risk before his admission can be legitimate. This is in addition to the 2003 Act's

³⁷ Emphasis added.

³⁸ Emphasis added.

³⁹ Richardson committee, *supra* n.32, at para.5.95.

impaired decision-making test. Section 44(4) makes short-term detention⁴⁰ in hospital contingent on the following conditions: (a) the patient must have a mental disorder; (b) his ability to make decisions about his treatment must be significantly impaired by that disorder; (c) it must be necessary to detain the patient in hospital in order to (i) determine what treatment he should receive, or (ii) give him that treatment; (d) *if the patient were not detained in hospital there would be a significant risk (i) to the health, safety or welfare of the patient, or (ii) to the safety of any other person*;⁴¹ and (e) the granting of a short-term detention certificate is necessary. In a similar vein, a longer-term⁴² compulsory treatment order may only be granted by a tribunal where it is satisfied that (a) the patient has a mental disorder; (b) medical treatment is available which would be likely to (i) prevent that mental disorder worsening, or (ii) alleviate any of the symptoms of it; (c) if the patient were not provided with such medical treatment *there would be a significant risk (i) to his health, safety or welfare, or (ii) to the safety of any other person*; (d) because of the mental disorder the patient's ability to make decisions is significantly impaired; and (e) the making of a compulsory treatment order is necessary in the patient's case.⁴³ It is clear that the 2003 Act's impaired decision-making test is merely complementary to, and not a substitute for, considerations of a patient's risks. Even where there has been a concerted effort to move

⁴⁰ Short-term detention lasts for up to twenty-eight days. See, Mental Health (Care and Treatment) (Scotland) Act 2003, s.44(5)(b).

⁴¹ Emphasis added.

⁴² The compulsory treatment order lasts for up to six months in the first instance (Mental Health (Care and Treatment) (Scotland) Act 2003, s.64(4)(a)(i)) and is renewable for a further six months (Mental Health (Care and Treatment) (Scotland) Act 2003, s.88(4)(a)) and then annually thereafter (Mental Health (Care and Treatment) (Scotland) Act 2003, s.88(4)(b)).

⁴³ Mental Health (Care and Treatment) (Scotland) Act 2003, s.64(5). Emphasis added.

away from the language of risk in mental health law, it has continued to apply to the compulsory powers implicitly. There is simply no alternative.

The idea that there is a similar tension between capacity and risk to that which exists between legalism and medicalism has perpetuated a false dichotomy. The legalism-medicalism debate accepts that mental health law must discharge a protective function – the only question is: how much of a role should the law play in doing that? The capacity-risk debate which we discussed in chapter one entails no such consensus – at least not expressly. Proponents of capacity play down the significance of public safety concerns whereas risk-based frameworks facilitate coercive control. In this way, they argue for completely distinct legislative frameworks which would operate in quite different ways. This has led to the mistaken characterisation of mental health legislation which is illustrated by *figure 5.2.:*

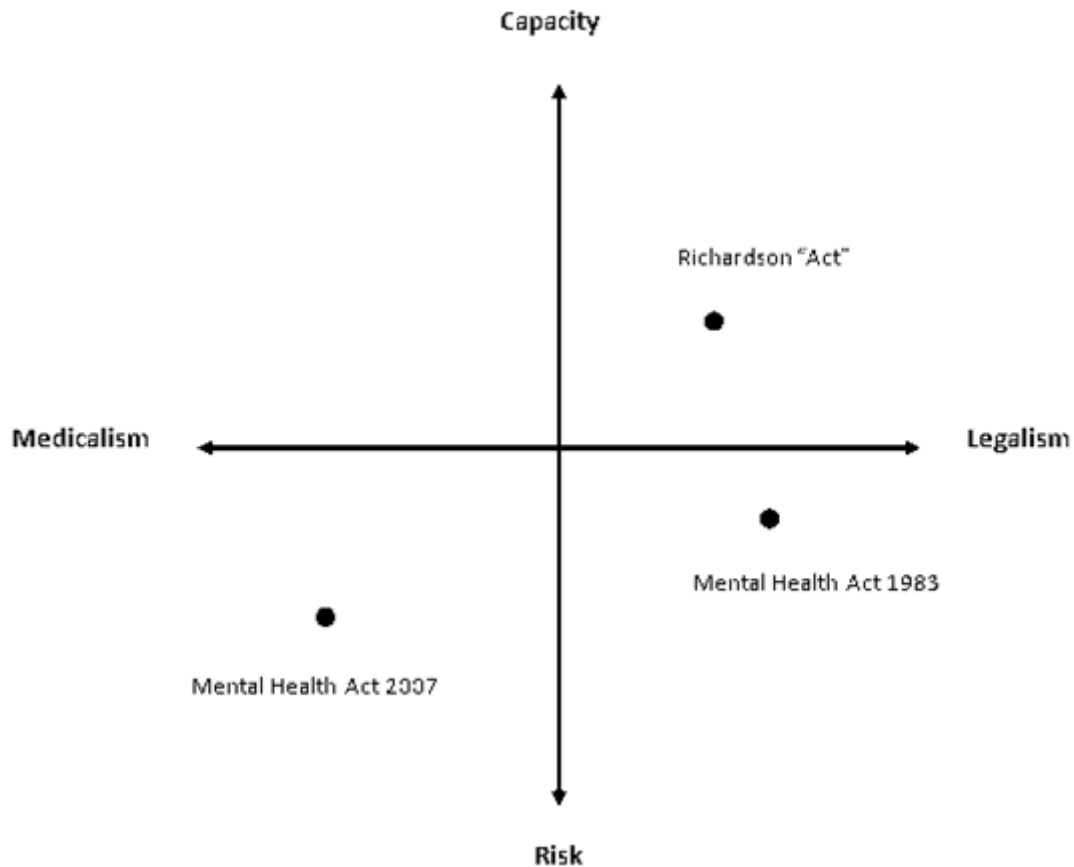


Figure 5.2. An axis showing how one might categorise mental health legislation according to how legalistic/medicalistic it is and the extent to which considerations of a patient’s capacity or risk should influence the outcome of compulsory decision-making processes. In truth, the vertical axis is a false dichotomy because risk and capacity are not mutually exclusive.

In reality, there is *no* tension between capacity and risk in coercive mental health legislation because the former cannot exist in the absence of the latter and still hope to achieve the same objectives. The idea that the two concepts are mutually exclusive is misconceived. First, if a mental health statute authorised the deployment of the compulsory powers on the grounds of a person’s capacity alone it would not have any protective function on which to justify coercion to protect the patient or the public. Indeed, there would be very little ‘coercion’ at all. This was neither the intention of the Richardson Committee nor is it the effect of the Mental Health (Care and Treatment) (Scotland) Act 2003. While it is true that these frameworks adopted an impaired decision-making test, they did not abolish risk as the

principal determining consideration. The distinction between the 2007 Act (lower left quadrant) and the Richardson Committee's proposed framework (upper right quadrant) illustrated by *figure 5.2* is therefore false: both 'statutes' have, or would have had, the effect of legitimising the compulsion of the mentally ill on the basis of risk. Secondly, it is not the case that risk-based regimes like the 2007 Act preclude decision-makers from considering the capacity of their patients. A person of full capacity suffering from a mental disorder can receive care and treatment in hospital *without there being any recourse to the MHA*. He can also decline such treatment if he so chooses. Decision-makers will therefore have to consider a patient's capacity long before admitting him to hospital. The Richardson Committee and any other statute which purports to emphasise capacity merely codifies practices which decision-makers already employ. Risk was and always will be the key to the compulsory powers: it is both an inevitable and irreplaceable feature of the statutory framework.

2.3.4. Risk and Health

The MHA draws an indissoluble link between a patient's risk profile and his mental health. The issue of risk becomes germane only where a patient is suffering from a mental disorder. A failure to account for risks will therefore have a detrimental effect on a patient's mental health. Similarly, if mental health practitioners do not treat a person's mental disorder they will do nothing to attenuate the risks of adverse outcomes that may be attendant on it. Let us consider 'Jim' again. If Jim declines treatment for his depression on a voluntary basis, his clinical team is likely to recommend his admission for treatment under section 3 of the MHA in light of the risk he poses to himself. Here, Jim's poor mental health has contributed *directly* to his risk profile, which in turn justifies his admission to hospital. It

must be remembered that the point of Jim's admission is that he should receive treatment in hospital *for his mental disorder*. The aim of this intervention is therefore twofold, (i) reduce or extinguish the risk of self-harm, and (ii) cure, or at least stabilise, Jim's mental disorder. These two considerations are plainly inseparable. It would surely pervert decision-makers' professional obligations to avoid harm and improve the health of their patients were risk *not* germane to their decisions. By amalgamating health and risk, the MHA allows decision-makers to make such an intervention in the interests of the patient. The same point applies to 'Kate', an adult patient suffering from schizophrenia. As part of her mental disorder, Kate manifests psychotic symptoms which have caused her to believe falsely that her ex-boyfriend is involved in a conspiracy to kill her. In order to protect herself from this perceived threat, Kate has taken to carrying a knife in public which she says she will use against her ex-boyfriend if she sees him. Like Jim, Kate has refused medical treatment and indeed disputes that she is suffering from a mental disorder at all. Again, the clinical team is likely to conclude that Kate poses a risk, albeit this time to other people. Her compulsory admission to hospital would therefore be justified on the basis that such an intervention is necessary for the purposes of protecting other people from the harm that Kate may cause *as a consequence of her suffering from a mental disorder*. There can be no disputing the fact that this intervention would have incidental benefits for Kate's mental health too. It would no doubt be beneficial if, for example, her clinical team could help to alleviate her psychotic symptoms. It is true that Jim and Kate's compulsory admissions to hospital would in part be exercises in social control – their respective risk profiles will be the 'spark' which engages the MHA's compulsory powers. However, the level of risk that they both pose is *directly linked* to their mental health and offers proof that their conditions are of such a nature or degree that it is appropriate for them to receive medical treatment in hospital.

Consequently, risk and health might be regarded as inversely proportional; the riskier a patient is the worse his health is likely to be and therefore the stronger the case for compulsion, while a patient presenting with comparatively low risks is likely to enjoy better mental health and is therefore unlikely to warrant detention under the MHA. There is a crude illustration of this relationship in *figure 5.3* below. This inverse proportionality also explains why there is no power in the law to intervene to reduce or extinguish the risks posed by people who do not suffer from a mental disorder; in those circumstances there would be no link between risk and the patient's health which would offer grounds for coercion. As we can see, the lazy characterisation of risk as an instrument of social control unrelated to health (see chapter one) conceals that the concept is in fact intimately bound up with the patient's wellbeing.

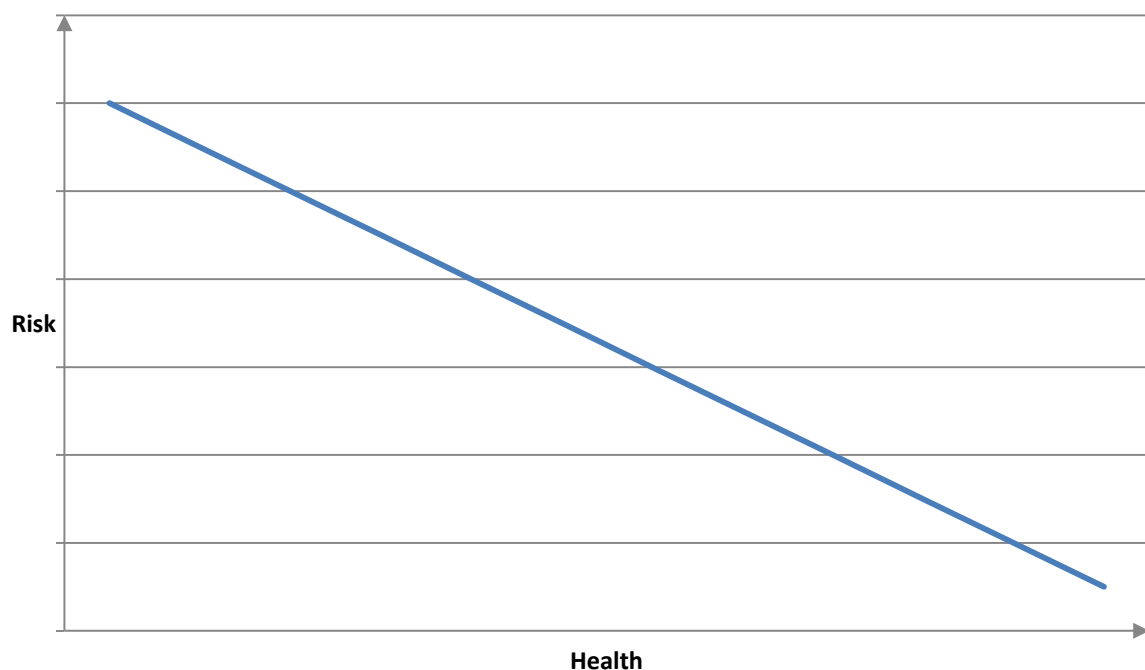


Figure 5.3. A line graph to illustrate the inversely proportional relationship between the state of a person's mental health and the degree of risk that he poses to himself or other people.

The courts have recognised that there is a relationship between therapeutic considerations and questions of risk. In MD v Mersey Care NHS Trust,⁴⁴ the Upper Tribunal (UT) addressed the issue of whether the nature of the risk posed by a patient detained under the MHA was relevant to the appropriateness of treatment for the purposes of section 72(1)(b)(ia). The UT rejected the suggestion put forward by counsel that considerations of a patient's risks should not trespass into the realm of therapy. Jacobs J said that the appropriateness of a particular treatment 'is determined by the patient's medical condition and the risk a patient presents is a consequence or feature of that condition.'⁴⁵ While the different paragraphs of section 72(1)(b) of the MHA raise separate issues,⁴⁶ it is not the case that evidence relating to one such issue is irrelevant to another. In support of this decision, the UT cited with approval the speech of Latham J in R v London South and South West Region Mental Health Review Tribunal, ex parte Moyle.⁴⁷ Here, His Lordship said that while the legal tests may be different, (i.e., section 72(1)(b)(i) refers to an 'appropriateness' standard, whereas section 72(1)(b)(ii) refers to 'necessity'), the facts relating to one of the tests may still determine the application of another. In other words, conclusions about a patient's health and risk can be based on the same factual nexus.

⁴⁴ [2013] UKUT 127 (AAC).

⁴⁵ *Ibid*, per Jacobs J at para.9.

⁴⁶ MHA 1983, s.72(1)(b) (as amended) states that a Mental Health Review Tribunal shall direct the discharge of a patient liable to be detained otherwise than under s.2 if it is not satisfied that – (i) he is then suffering from a mental disorder of a nature or degree which makes it appropriate for him to be liable to be detained in a hospital for medical treatment; or (ii) it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment; or (ia) appropriate medical treatment is available for him; or (iii) in the case of an application by virtue of paragraph (g) of s.66(1), the patient, if released, would be likely to act in a manner dangerous to other persons or to himself.

⁴⁷ [1999] MHLR 195.

It cannot be denied, of course, that the inclusion of risk in the statutory framework confers a special status on mental illnesses which does not extend to their physical equivalents. This is illustrated by the Court of Appeal's decision in St George's Healthcare NHS Trust v S.⁴⁸ S, a pregnant woman of full capacity, was diagnosed with pre-eclampsia at thirty-six weeks. She did not suffer from a mental disorder. Her clinical team advised her to consent to urgent medical treatment in light of the grave risks her condition posed to her life. S refused. Consequently, her clinical team recommended that S be admitted to hospital under section 2 of the MHA. The Court of Appeal held that the civil commitment provisions could not be used to override a patient's refusal to give consent, even if that decision might seem irrational.⁴⁹ For that reason, S had been unlawfully detained under the MHA. If a patient with a physical condition refuses to consent to medical treatment that might save her life the risks are immaterial: if she has capacity then her clinical team must respect her wishes. By contrast, had S been suffering from a mental disorder at the material time, she would probably have received treatment for pre-eclampsia under the MHA on the bases that (i) her refusal to consent to urgent treatment was a manifestation of her mental disorder and (ii) administering it would help to stabilise her condition and thereby facilitate the treatment of her schizophrenia.⁵⁰ The confluence of mental illness and risk is therefore a uniquely powerful combination which sets psychiatric care and treatment procedures apart from their physical counterparts. Yet this distinction can seem strange. If clinicians can use the concept of risk for the benefit of patients' mental health, why does it not inform their

⁴⁸ [1998] 3 WLR 936.

⁴⁹ *Per* Judge LJ, at 957.

⁵⁰ See, e.g., Tameside and Glossop Acute Services Trust v CH [1996] 1 FCR 753; and B v Croydon Health Authority [1995] Fam 133.

care and treatment of physical disorders too? Indeed, why does no physical disorder have its own risk-based statutory framework governing its care and treatment arrangements? If a person with photosensitive epilepsy, for example, continues to drive a car contrary to medical advice and thereby poses a risk of harm to other road users, there is no equivalent form of coercion which can legitimately prevent him from doing so. How can such a flimsy distinction be justified? With admitted difficulty: the strongest case against risk is that there is little to justify a distinction between mental and physical illnesses in principle and therefore the concept's importance in relation to the former seems rather incongruous. However, the epileptic driver who chooses to drive a car contrary to medical advice will be in breach of his duty to other road users and may even be liable to prosecution for committing a criminal offence, but this only applies *after he has caused injury, loss or damage to others*. As we saw in chapter three, the MHA explicitly empowers decision-makers to intervene in the interests of a patient's health or safety or for the protection of others *before an adverse incident even occurs*. In principle there is no reason why this distinction should apply: anyone can pose risks to himself and other people and a patient's being at liberty only increases the likelihood of hazardous outcomes. In practice, however, we know that mental health decision-making involves so much uncertainty that it is necessary to rely on a concept like risk in order to anticipate adverse outcomes. Indeed, it seems that the high degree of uncertainty extant in mental health decision-making is the only thing that can really justify this distinction. Whereas the nature and degree of physical disorders are fairly predictable and understood, the same cannot be said of mental illnesses. This uncertainty explains why risk is so central to mental health law and less relevant in other fields.⁵¹ As we saw in part 2.2, mental health decision-makers must deal with so much

⁵¹ Mental health law does not have an exclusive monopoly on risk; the concept plays a role in laws

uncertainty that they have to practise according to a distinct framework of rules, which they often choose to overlook or sidestep to achieve a desired outcome. It may not be a logically satisfactory arrangement, but then the quest for logical purity in this field may always be a futile endeavour.

2.3.5. The Certainty of Risk

Finally, the inclusion of risk in the MHA may do more to promote certainty than the conventional wisdom would suggest. If virtually anything about a patient's mental health, characteristics or circumstances can be construed as evidence of his posing risk then the law theoretically does very little to prevent arbitrary decision-making. This makes it difficult for a patient to predict how his clinical team might interpret his mental health status; he is therefore unable to anticipate with any certainty what the outcome of an assessment of his risks might be.

Yet this problem with risk must be located in its wider context: it is *not* the case that the entirety of a patient's engagement with mental health services is beset by uncertainty. While a patient's risks will engage the compulsory powers, his subsequent interactions with mental health services are determined by the provisions of the MHA. The statutory framework contains concrete procedural protections which are both prescribed by law and

governing physical health too. There are two examples. First, Part IIA of the Public Health (Control of Disease) Act 1984, inserted by the Health and Social Care Act 2008, s.129, empowers a Justice of the Peace to make an order under s.45G authorising the detention in quarantine of a person suffering from a communicable disease where (i) there is a risk that that person might infect or contaminate others, and (ii) the order is necessary to remove or reduce that risk. Secondly, case law predating the Mental Capacity Act 2005 suggests that the level of capacity required before a patient can refuse medical treatment must be commensurate with the risks such a refusal may pose to his life. There is no reason to believe that this principle is no longer good law following the introduction of the 2005 Act. See, e.g., Re T (Adult: Refusal of Treatment) [1992] 3 WLR 782. Notice that an assessment of risk precedes and legitimises the deployment of coercive power or the overriding of a person's right to self-determination in these contexts too.

accessible to the patient. They ensure that the nature and extent of his interaction with mental health services are predictable and knowable. For example, a person with mental disorder can know that he may be detained for up to twenty-eight days if he is admitted for assessment⁵² or six months if he is admitted for treatment.⁵³ The MHA imposes clear limits on the duration of authority in cases of emergency⁵⁴ or where the relevant person is already in hospital as a voluntary or informal patient.⁵⁵ It also provides the legal basis for the renewal of the patient's detention,⁵⁶ his discharge,⁵⁷ and his involvement in key treatment decisions.⁵⁸ Once a patient is deemed to pose a risk to himself or others, this engages the MHA which in turn dictates how long mental health services can hold him, what they can do to him, and when they should release him. It is not the case that a patient subject to the compulsory powers will find himself in a continuing state of uncertainty because the concept of risk lacks a 'legal' definition. The MHA also imposes checks and balances on the practitioners authorised to apply for, and recommend the deployment of, the compulsory powers. For example, two registered medical practitioners must recommend a patient's admission for assessment⁵⁹ or treatment⁶⁰ following an initial application by an approved

⁵² MHA 1983, s.2(4).

⁵³ MHA 1983, s.20(1).

⁵⁴ 72 hours from the time when the patient is admitted to the hospital, see MHA 1983, s.4(4).

⁵⁵ 72 hours from the time when a registered medical practitioner furnishes a report to the hospital managers; and six hours from the time when a nurse of the prescribed class records that the patient is suffering from a mental disorder of the requisite nature and degree but that it is not practicable to ensure the immediate attendance of a practitioner, see MHA 1983, ss.5(2) and (4).

⁵⁶ MHA 1983, s.20.

⁵⁷ MHA 1983, ss.23, 25.

⁵⁸ MHA 1983, Part IV.

⁵⁹ MHA 1983, s.2(3).

mental health professional (AMHP) or the nearest relative.⁶¹ This tripartite decision-making dynamic theoretically blends the medical and social models to ensure that the patient's admission has a broad basis reflecting his clinical and care needs. On the medical side there are further such checks: one of the medical recommendations must be given by a practitioner approved by the Secretary of State as having special experience in the diagnosis and treatment of mental disorders; the other should be given by a clinician who has a previous acquaintance with the patient.⁶² These medical recommendations must follow the doctors' examinations of the patient, which they may undertake separately or together,⁶³ and they must agree that the criteria for compulsory admission to hospital are satisfied.⁶⁴ In the case of admission for treatment, the doctors must also include further particulars and a statement of the reasons why they have concluded that the patient poses a risk.⁶⁵

There are two consequences of the MHA's procedural framework to consider here. First, it establishes a high threshold for decision-makers to discharge before they can deploy the compulsory powers. This reinforces the fact that the MHA expects that decision-makers will not resort to the compulsory powers lightly. Secondly, and as a corollary, it confers the power of veto on each decision-maker. In the event of a disagreement between either the two clinicians or the doctors and the AMHP then a patient's admission to hospital is *not* authorised under the MHA. All three decision-makers must agree before the compulsory

⁶⁰ MHA 1983, s.3(3).

⁶¹ MHA 1983, s.11(1).

⁶² MHA 1983, s.12(2).

⁶³ MHA 1983, s.12(1).

⁶⁴ MHA 1983, ss.2(3) and 3(3).

⁶⁵ MHA 1983, ss.3(3)(a) and (b).

powers can be deployed. Similar checks apply in other parts of the MHA, for example, in relation to supervised community treatment,⁶⁶ renewal,⁶⁷ and certain medical treatments.⁶⁸ If three practitioners drawn from different professional backgrounds have to agree in order to detain the patient this means, *a fortiori*, that they must also share the same conclusions about a patient's risks. This weakens the argument that almost anything goes in relation to risk: the MHA's framework is specifically engineered to prevent one decision-maker's arbitrary or inadequate assessment of a patient's profile from having a determinative effect. This veto power adds another layer of protection for patients from arbitrary decision-making. Although risk assessments necessarily entail uncertainty, the MHA framework into which they lead contains explicit provisions whose operation can be known by the patient. While he may not be able to predict whether he will be assessed as a risk for the purposes of the MHA, the patient is able to anticipate what the consequences of such an assessment might be. In fact, that patient is arguably in a *more* certain position than one engaged by mental health services on a voluntary basis outside the ambit of the MHA. Although this patient cannot be admitted to hospital or given treatment without his consent, there is a great deal more uncertainty about the nature, extent and duration of his interaction with his clinical team than exists in the case of a formal patient. There are no special rules

⁶⁶ The responsible clinician may only make a patient subject to a CTO where the relevant criteria are met and an AMHP states in writing that he agrees with the clinician's opinion and thinks it appropriate to make the order; see MHA 1983, ss.17A(4)(a) and (b).

⁶⁷ Within two months of the day on which the patient's liability to be detained under the MHA is due to cease, a responsible clinician must furnish the hospital managers with a report setting out the reasons why the admission criteria continue to apply and requesting a renewal of the patient's detention. Before doing this, the responsible clinician must secure the agreement of another person who has been professionally concerned with the patient's treatment but who does not belong to the same profession as the clinician, e.g., an AMHP, see MHA 1983, s.20.

⁶⁸ The MHA mandates that certain medical treatments can only be administered where the responsible clinician has secured the second opinion of another medical professional; see MHA 1983, Part IV.

governing how mental health practitioners should diagnose a voluntary patient's mental disorder, no time limits on the duration of his engagement, and no statutory discharge procedure. A patient diagnosed with a mental disorder but deemed not to pose a risk to himself or others therefore faces the prospect of a lengthy interaction with mental health services. Contrary to the conventional wisdom, risk can in fact inject *greater* certainty into a patient's position.

2.4. Conclusions

The 2007 Act sought to create a regulatory regime for the management of risks posed by people suffering from mental disorder. This is a clear departure from the priorities of 'conventional' medicalism. Consequently, the 2007 Act is based on a distinct philosophical foundation, New Medicalism, which encompasses two aims: (i) reduce the determinative power of mental health law, and (ii) enhance decision-makers' responsiveness to risk. These objectives might be regarded as unsatisfactory from a legal point of view because they play down the law's significance in order to lend greater prominence to an ill-defined concept of risk in the decision-making process. Yet, as we have seen, New Medicalism represents a realistic and pragmatic underpinning for coercive mental health legislation.

There are two reasons for this. First, mental health practice is beset by uncertainty. Statutory provisions governing decision-making in this field will always struggle to reconcile the hard edifice of the law with the exigencies of practice. Secondly, the concept of risk is a practical device on which to base the compulsory powers. Risk has been a constant feature – either implicitly or otherwise – of mental health legislation for a long time. It is both an inevitable and irreplaceable component of the compulsory powers. It enables mental health professionals to tailor their interventions to suit their patients' needs, meaning that there is

no presumption of compulsion simply because someone has a mental disorder. The concept is intimately linked with broader questions relating to a patient's health and it is the gateway to the comprehensive framework of patient-centric rights and duties which appears in the MHA. While there may be much to criticise about medicalistic and risk-based mental health laws, there are no alternative legal devices which could achieve the same ends so effectively. Even though at times this arrangement may lack logical purity, the fact that the 2007 Act seems to get the job done with apparently no major adverse consequences for decision-makers and patients is clearly to its credit.

3. They Just Know it When They See It: On Decision-makers' Tacit Knowledge of Risk

3.1. Should there be a Statutory Definition of 'Risk'?

Even if one accepts New Medicalism as a suitable policy basis for compulsory mental health legislation, this still leaves us with a problem: the model does not define 'risk'. Mindful of the fact that New Medicalism creates a regime by which mental health professionals regulate patients' risks, the omission of a statutory definition of the concept might seem like a significant oversight. Indeed, now that the MHA actually features the word 'risk' there is surely an argument that decision-makers are in even greater need of guidance which might aid their interpretation of the concept. As Glover-Thomas argues, there are two possible consequences of indistinct criteria: (i) they jeopardise patients' rights, and (ii) they undermine public trust in mental health services.⁶⁹ Following the

⁶⁹ N. Glover-Thomas, 'The Age of Risk: Risk Perception and Determination Following the Mental Health Act 2007' (2011) 19 *Medical Law Review* 581, at p594.

introduction of the 2007 Act, surely even the *potential* for mental health decision-making to become less consistent intensifies the need for a statutory definition of risk?

Not necessarily. The argument for embedding a definition of 'risk' (or at least a gloss of the so-called 'risk formula') in the MHA is based on two flawed assumptions. First, it supposes that mental health professionals would interpret risk with reference to a definition given by a statute and act accordingly. In truth, there is little evidence to suggest that mental health decision-makers would consider themselves so constrained. As we saw in chapter four, the determinative power of mental health law is weak; it is not uncommon for a statutory framework to fail to achieve its policy objectives or map decision-making practice. It does not follow, therefore, that a definition of 'risk' incorporated into the MHA's civil commitment provisions would eliminate inconsistencies from practitioners' assessments of patients' risks. Indeed, it is doubtful that mental health practitioners would comply slavishly with such a definition when they have been willing to sidestep, or make 'creative' use of, the MHA in other circumstances. It may be that they would either ignore the new definition or rely on it only to the extent that it does not clash with their pre-existing working constructions of the concept. A statutory definition of 'risk' is therefore unlikely to be as conclusive as one might expect. Moreover, the idea of establishing a legalistic definition in this way must surely run counter to the spirit of the New Medicalist paradigm. Once we embark on a quest to define 'risk' and prescribe its application, we must accept that we are then in retreat from New Medicalism and therefore renouncing the virtues of risk-based mental health laws.

Secondly, proponents of defining 'risk' assume it is possible to formulate a definition of the concept which can encompass the entire range of its likely application with sufficient precision to guarantee its consistent use. This is much more difficult than it seems. Let us

consider section 3(2)(c) of the MHA 1983, for example. How might we incorporate a definition of risk into the criteria for compulsory admission for treatment? There are several ways Parliament might consider doing it. The first is simply to insert the word 'risk' into the paragraph so that it becomes explicit that the relevant decision-makers are concerned with its assessment and management. It might look like this:

(2) An application for admission for treatment may be made in respect of a patient on the grounds that –

...

(c) **he poses such a risk that** it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section...

Then, a new paragraph could be inserted into section 145(1), which glosses a number of other terms which appear in the MHA. This might say something like:

(1) In this Act, unless the context otherwise requires –

...

“risk” refers to the likelihood that a person suffering from a mental disorder within the meaning of section 1(2) above will cause harm to his health or safety or to the health or safety of other persons as a result of his

mental disorder, and related expressions shall be construed accordingly.

This approach has the advantage of establishing a threshold for action which does not exist under the current framework. The reference to ‘likelihood’ under the amended section 145(1) – when read in conjunction with the amended section 3(2)(c) – would imply that there must be evidence that the patient would be *likely* to harm himself or other people as a result of his mental disorder if he were to remain untreated. This suggests that ‘sectioning’ decisions would depend on the balance of probabilities.⁷⁰ This is clearly a more exacting standard than that which exists under the current framework. Yet, it is difficult to see what the inclusion of ‘risk’ in this way would add to section 3(2)(c) of the MHA 1983; a literal interpretation of the paragraph *without* the word would almost certainly have the same effect. The inclusion of ‘risk’ here may be tautological and unnecessary. Moreover, this proposed amendment would fundamentally recalibrate decision-making practices by *raising* the threshold for admission. There is no doubt that these amendments would have quite the opposite effect from that which New Medicalism seeks to achieve. A second option might be to redraft section 3(2)(c) and insert a new subsection (5) to assist in its interpretation:

(2) An application for admission for treatment may be made in respect of a patient on the grounds that –

...

⁷⁰ This would mean that the likelihood of an adverse outcome would have to exceed 50 *per cent* before the relevant decision-makers could recommend admission under the MHA. On this point, see Gregg v Scott [2005] UKHL 2; Hotson v East Berkshire Area Health Authority [1987] 1 All ER 210, CA.

(c) he poses a risk of harm to himself or other people

making it necessary to receive such treatment and it cannot be provided unless he is detained under this section...

...

(5) In this Act, 'harm' means injury or damage and includes suicide, self-harm, self-neglect, exploitation, and violence against people or property; 'risk' refers to the chance of harm occurring; 'risk of harm' shall be interpreted accordingly.

Here, the drafting would limit decision-makers' assessments of risk to specific *types* of harm, thereby restricting the reach of the MHA. These amendments would ensure that mental health practitioners only take the chance of injury or damage into account, meaning that a patient's detention could not be justified on a trivial basis. Once again the provisions would define risk, only this time they refer to *chance*, which seems to be a less testing standard than the balance of probabilities from the first example. Yet again, however, the drafting seems unsatisfactory: it merely rehearses the current MHA's provisions, thereby preserving many of the current difficulties of interpretation. It purports to restrict civil commitment to occasions where a patient poses a risk of causing a specific type of harm, thereby limiting practitioners' competences in other circumstances which the draftsman has not anticipated. This amounts to an appropriation of clinical competence by Parliament which transforms professionally qualified decision-makers into mere agents of coercion. Indeed, this example would actually *worsen* the definitional problem: why even include the word 'risk' if it should be taken to mean 'chance'? Unless they are intended to have distinct meanings, surely one

of those words is redundant? Why not simply redraft section 3(2)(c) to read ‘...there is a chance that he will cause harm to himself or others’? There is a danger when a statute seeks to confer a special meaning on certain terms that it will have the incidental effect of creating new definitional problems for each one it solves. This may also be a consequence of our third and final proposal:

(2) An application for admission for treatment may be made in respect of a patient on the grounds that –

...

(c) he poses a substantial risk of serious harm to

(i) his health or safety, or

(ii) other people or property,

making it necessary that he should receive such treatment and it cannot be provided unless he is detained under this section...

This borrows the wording of the Richardson Committee’s admission criteria, which referred to ‘substantial risk of serious harm’.⁷¹ Presumably, the adjectives ‘substantial’ and ‘serious’ were intended to modify the nouns ‘risk’ and ‘harm’ in such a way as to impose a higher threshold for compulsion than exists under the current framework. Yet this formulation raises further questions about what ‘substantial’ and ‘serious’ mean; these terms simply compound, rather than clarify, the definition problem. While we might infer that something

⁷¹ Richardson Committee, *supra* n.35.

more than a mere risk is required in order to justify civil commitment, this example tells neither practitioners nor patients what will and will not discharge the threshold. As we saw in chapter three, the use of adjectives like ‘serious’ or ‘real’ assume that there is a ‘neutral’ definition of risk which can then be modified to extend or reduce its scope. No such starting point exists. In addition, it is not clear whether a ‘substantial risk of serious harm’ test would have a different effect from the current risk formula in practice. The most likely effect of a test based on the ‘substantial risk of serious harm’ would be to place a veil of procedural rigour over the decision-making process which would have virtually no bearing on mental health practice.

What becomes clear is that assumptions about the curative power of a statutory definition of ‘risk’ are misguided. It is not the case that such a definition would enhance the MHA framework. There are two reasons for this. First, it is simply impossible to compose a standard definition which can capture the essence of risk in mental health practice in the abstract. Previous attempts to establish a standard risk threshold have failed in other contexts because what amounts to a risk is a social as much as a technical phenomenon.⁷² In mental health practice, this is particularly pertinent: ‘risk’ may describe, or derive from, anything pertaining to a patient’s situation (e.g., his living arrangements), his diagnosis (e.g., suicide ideation) or his characteristics (e.g., his age). It might be a synonym for an adverse event (e.g., self-harm is risk), describe the patient as a kind of *pars pro toto* synecdoche

⁷² See, e.g., C. Starr, ‘Social Benefit versus Technological Risk’ (1969) 165(3899) *Science* 1232; S.R. Watson, ‘On Risks and Acceptability’ (1981) 1(4) *Journal of the Society for Radiological Protection* 21; S. Lichtenstein *et al*, ‘Judged Frequency of Lethal Events’ (1978) 4(6) *Journal of Experimental Psychology: Human Learning and Memory* 551; J.X. Kasperson, ‘The Social Amplification of Risk: Assessing Fifteen Years of Research and Theory’ in N. Pidgeon *et al* (eds.) *The Social Amplification of Risk*, Cambridge: Cambridge University Press, 2003; W. Leiss, ‘Searching for Public Policy Relevance of the Risk Amplification Framework’ in N. Pidgeon *et al* (eds.) *The Social Amplification of Risk*, Cambridge: Cambridge University Press, 2003.

(e.g., a particular risk factor inherent in the patient increases the likelihood of an adverse event, therefore the patient is a risk), or represent a calculus of probability (e.g., there is a strong likelihood that a patient may harm other people, therefore there is a risk). Perhaps deliberately, the MHA neither endorses nor excludes any of these interpretations; a risk in this context can therefore be a bad thing, a bad part of a bigger picture or the measure of the likelihood of a bad thing occurring. It could also be a bad thing that exists within acceptable – and therefore non-actionable – limits; not all risks will be actionable *per se*. It is plain, then, that the conceptual dimensions of risk are so complex that it is simply impossible to define the concept exhaustively for the purposes of the MHA. In *figure 5.4* below, which is adapted from the work of Lahtinen *et al*,⁷³ we can see how many distinct risk factors affect and can be affected by a patient's risk profile. Attempting to define the concept to restrict or encapsulate its various facets would be a futile exercise. The only thing that the definitions offered above seem to do is tinker around the edges or create fresh uncertainties, thereby falling short of providing any definitive meaning of risk. It is simply not possible for statutory definitions to be any more comprehensive than that which appears in the current MHA. It is submitted that this impossibility requires policy- and law-makers to leave the issue of risk to mental health professionals to determine as a matter of fact.

⁷³ E. Lahtinen *et al*, *Framework for Promoting Mental Health in Europe*, STAKES, Helsinki: National Research and Development Centre for Welfare and Health, 1999, at p30.

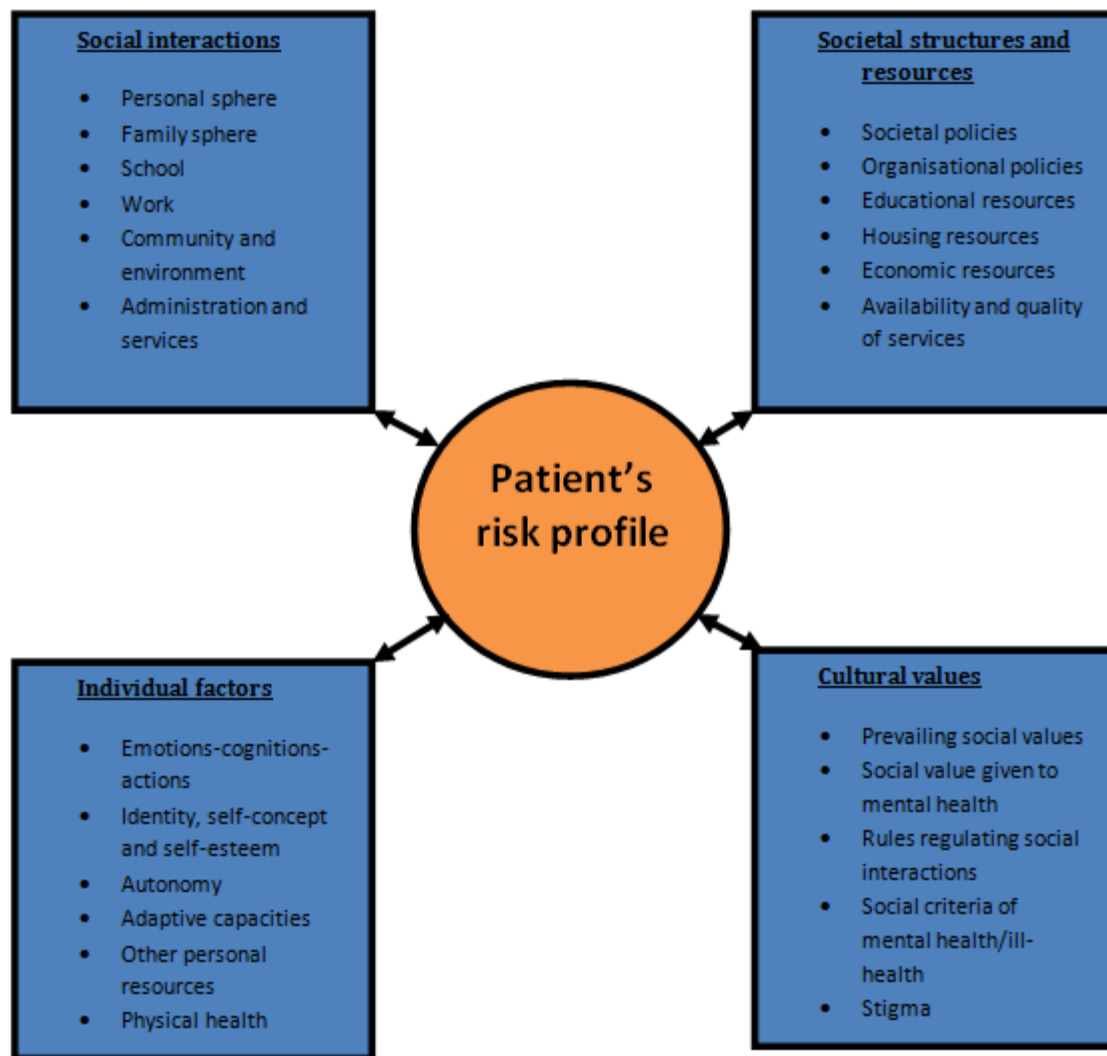


Figure 5.4. A diagram illustrating the complex and multi-faceted relationships which exist between risk and individual, cultural and social factors. This makes a comprehensive definition of ‘risk’ for the purposes of the MHA virtually impossible.

Secondly, even if it were possible to define ‘risk’ for the purposes of the compulsory powers, it is doubtful that it would be in any way desirable to include such a definition in the MHA. As we have seen, the advantage of New Medicalist frameworks like the 2007 Act is that they leave questions of diagnosis, care, treatment and risk to decision-makers. The law does not seek to second-guess or supplant the decisions of those on whom it confers decision-making authority. If a definition of ‘risk’ were included in the civil commitment framework, this overtly legalistic gesture would necessarily constitute a departure from New Medicalism. It would, in theory, bind mental health practitioners to a legally-

enforceable standard which would alter the decision-making dynamic and restore the primacy of the law. Of course, this assumes that the law has determinative influence, which, as we know, is questionable. Yet, in any event, it would add another legal basis on which to challenge the grounds of a patient's detention in hospital. While on the one hand this may be a desirable development, on the other it undermines the freedom decision-makers have to assess and interpret risk according to their expertise and experience. It also reinforces risk's reductive tendency by requiring mental health professionals to view their patients through the prism of a legal test. Decision-makers' understanding and interpretations of risk have developed according to their expertise and experience over many years. There is no way that a statutory provision could ever act as a substitute for this body of professional knowledge. It seems there is a danger that something apparently as simple as a definition would fundamentally alter the purpose and mechanics of mental health law. For that reason, it is undesirable for the MHA to define 'risk'.

3.2. Law is Not the Answer: the Stabilising Influence of Tacit Knowledge

The implication behind the argument for including a definition of 'risk' in the MHA does not flatter mental health practitioners because it reinforces the impression that in the absence of fixed legal standards their assessments of risk would take place in a kind of anarchic vacuum, thereby jeopardising liberty and facilitating control. In essence, this argument assumes that legal prescriptions are the *only* way to guarantee consistent practices among mental health professionals. While it is true that interpretations and assessments of risk may differ between practitioners and the law does nothing to prevent this, there is no evidence to suggest that a statutory definition of the concept would reduce

or avoid this variation. At the same time, the absence of such a definition has not contributed to a decision-making free-for-all in which patients are habitually admitted to hospital on spurious or illogical bases. Anarchy has not prevailed where the law's determinative influence is less keenly felt. Mental health decision-making therefore appears to conform to a sort of spontaneous order which has emerged quite independent of the law. As we saw in chapter four, since the 2007 Act came into force *something* has held the rate of civil commitments steady and ensured reasonably consistent use of the compulsory powers. It is submitted that this phenomenon may be attributable to decision-makers' tacit knowledge of what risk means and how it should be assessed.

In her work on the impact of the 2007 Act, Glover-Thomas interrogated the effect that the emphasis given to risk in contemporary mental health law and policy may have had on decision-making practices. Without a statutory definition of 'risk', her research team hypothesised that in every case mental health practitioners must look for certain 'ingredients' in their patients' profiles which contribute to a 'risk recipe' which in turn objectively satisfies the MHA's commitment criteria.⁷⁴ The research team thought that while decision-makers cannot know what the MHA's risk formula means in the abstract there must be a tacit consensus that certain factors will be probative of risk in each case. In other words, decision-makers will instinctively *know* a risk when they see one. If that is the case, there is no reason why the MHA could not codify these ingredients and thereby capture the essence of risk. In formulating this hypothesis, Glover-Thomas borrowed and adapted Honoré's idea that in the tort of negligence the cause of the claimant's injury, loss or

⁷⁴ N. Glover-Thomas, *An Investigation into Initial Institutional and Individual Responses to the Mental Health Act 2007: Its Impact on Perceived Patient Risk Profiles and Responding Decision-making*, Liverpool: the University of Liverpool, 2011, at pp37-8.

damage can be determined with reference to a 'recipe' of factors or ingredients, which may include the defendant's breach of duty.⁷⁵ Honoré argued that in order to be found to be the cause of a harmful event a defendant has to 'complete' a set of conditions sufficient to bring it about; i.e., his breach of duty must be among the 'ingredients' that cause or contribute to the claimant's loss, injury or damage.⁷⁶ The issue for the trial judge is to establish which ingredient is to be taken as the material cause of the claimant's loss. Consider two motorists, A and B, whose vehicles collide when A fails to adhere to the standard of care expected from a reasonably competent and experienced driver and crashes into B's car, which was travelling in the opposite direction.⁷⁷ There are many 'ingredients' which might be said to have caused the collision: A had recently passed his driving test, B had been delayed by five minutes before setting off on her journey, A and B were driving their respective cars on the same street in opposite directions at the material time, gravity precludes cars from flying over each other, the universe exists, etc. While any of these ingredients could be said to have caused the damage, the court's role is to identify the ingredient which would make *the defendant's breach* responsible for the loss, injury or damage. In this example, let us posit that A was also not exercising reasonable care and skill because he was trying to adjust his radio and was therefore not concentrating on the road immediately prior to the collision with B's car. Applying Honoré's model, this particular ingredient is likely to form the causal link between A's breach of duty and B's injury, loss or damage. This idea of a causal recipe is plainly a useful analogy by which the court can

⁷⁵ T. Honoré, *Responsibility and Fault*, Oxford: Hart Publishing, 1999.

⁷⁶ *Ibid*, at p120.

⁷⁷ Nettleship v Weston [1971] 2 QB 691, CA.

narrow its focus onto the material factor(s) in a negligence claim.⁷⁸ Glover-Thomas hypothesised that the decision-making process in the MHA must work in a similar way: practitioners must look for factors or ‘ingredients’ in a patient’s profile which are indicative of his risks. She thought that while some ingredients will have no bearing on an assessment of risk, other factors may complete a ‘recipe’ and thereby justify compulsion under the MHA. It is for clinicians and other allied professionals to identify which ingredients contribute to patients’ risk profiles. In the event, all of the participants in the Mersey Care study accepted that these risk assessments are at least broadly analogous to the process of following a recipe.⁷⁹ Yet they were either unwilling or unable to offer examples of ingredients or combinations of ingredients which might culminate in a decision to detain a patient under the MHA.⁸⁰ The participants were even less enthused by the research team’s suggestion that the list of ingredients might be codified in a Schedule to the MHA. As Glover-Thomas subsequently concluded, it would be a ‘hopeless’ (and presumably impossible) task for Parliament to codify a comprehensive list of risk factors limiting the reach of the compulsory powers.⁸¹ While the analogy of a recipe may informally illustrate decision-makers’ processes, Glover-Thomas’ work suggests that it would be impossible to apply the model in a formal legalistic context.

In truth, Honoré’s recipe idea has a limited application to the MHA’s compulsory powers. This stems from two fundamental problems. First, Honoré conceived the recipe

⁷⁸ This process is not always as straightforward as it seems; see, e.g., Wilsher v Essex Area Health Authority [1988] 1 All ER 871.

⁷⁹ Mersey Care study, *supra* n.74, at pp49-50.

⁸⁰ *Ibid.*

⁸¹ Glover-Thomas, *supra* n.69, at p600.

analogy to explain the way the courts establish causation in negligence. This is a particularly narrow application that has little in common with an assessment of risk under the MHA. In the law of tort, the issue of causation links the defendant's breach and the claimant's loss in order to establish liability. If no such link can be drawn then a claim will fail.⁸² Therefore, the injury, loss or damage *will already have occurred* by the time the claim is heard; the task of the decision-maker – in this case, the judge – is simply to identify the material ingredient(s) as part of a *post hoc* enquiry into the cause of the claimant's loss. By contrast, the MHA's civil commitment powers can be deployed prospectively, i.e., *before* the patient has actually caused harm to himself or others as a result of his mental disorder. Here, the task of identifying the material ingredient(s) contributing to a risk recipe rests on decision-makers' predictions. This means either that the ingredients will not necessarily exist at the time of the assessment or decision-makers will attribute significance to otherwise-neutral factors as harbingers of future harm. The fact that the assessment of risks in mental health practice necessarily entails speculation about the likelihood of harm occurring in the future means that the recipe analogy is less compelling here than it is in the law of tort.

Secondly, talk of 'ingredients' and 'risk recipes' implies a high degree of certainty which, as we have seen, mental health decision-making lacks. For example, a recipe for a chocolate cake is likely to comprise ingredients like flour, sugar, eggs, cocoa powder and chocolate. If any of these were to be omitted, the person following the recipe would struggle to bake a chocolate cake. More significantly, if any of the ingredients were to be substituted for other things then the person following the recipe would no longer be baking a chocolate cake at

⁸² See, e.g., Barnett v Chelsea and Kensington Hospital Management Committee [1969] 1 QB 428; Bolitho v City and Hackney Health Authority [1997] 4 All ER 771; McWilliams v Sir William Arrol and Co Ltd [1962] 1 WLR 295.

all. A recipe is a list of ingredients and a set of instructions which a person must follow in order to produce a particular outcome. Any deviations from a recipe will result in a different outcome from the one that the chef intended. Furthermore, recipes typically specify certain *quantities* of ingredients; using the example of a chocolate cake, the recipe might include 200g of flour, 350g of sugar, and 200g of chocolate, etc. Any variation of these quantities is likely to affect the end-product. If this variation is significant, the end-product might not be a chocolate cake at all. The point is that where a recipe analogy has been invoked we might expect that (i) the end product is well-defined, and (ii) its constituent ingredients are specified and properly quantified. Honoré's causal recipe satisfies these requirements: (i) the end-product it seeks to establish is a causal link between the defendant's breach and the claimant's loss in a negligence claim, and (ii) the principal ingredient is evidence of a want of care on the part of the defendant, which must be at least a probable cause of the claimant's injury, loss or damage.⁸³ In the absence of this evidence, there will be no causal link and therefore no liability for negligence. Honoré's construction of causal recipes therefore passes what we might call the 'chocolate cake' test. Glover-Thomas' 'risk recipe', by contrast, does not. There is no agreement about what a risk is in the abstract, meaning that there is no specific end-product. As we have seen, 'risk' could refer to a *tangible* hazard (e.g., self-harm) or to the *likelihood* of a particular adverse outcome occurring (e.g., it is *likely* that a patient might commit suicide if he is left untreated). Anyone following one of Glover-Thomas' risk recipes would not necessarily know what he was making; there is a clear difference between the certainty of a hazardous outcome and the mere likelihood of one. More importantly, there is no ingredient or combination of ingredients which might be

⁸³ See, e.g., Loveday v Renton [1990] 1 Med LR 117.

probative of a patient's risks for the purposes of such a recipe. There is a litany of factors that decision-makers might take into account in an assessment of a patient's risks. Some might amount to a risk that warrants action while others may not. A factor like the patient's history of self-harming behaviour might persuade a decision-maker that a particular patient is a risk to himself, whereas that same ingredient might not be considered particularly relevant in an assessment of another patient. There is also no agreement about the requisite *quantity* of such factors: how recently should the patient have exhibited self-harming behaviour? How grave should his self-harming tendencies have been? What steps ought to be taken to reduce the risks prior to resorting to the MHA? The idea of a risk recipe does not answer these questions: a decision-maker can apparently justify his conclusion that a patient poses a risk on the basis of the existence (or absence) of an enormous range of ingredients which may be present (or absent) in varying quantities and with varying intensities. This is rather like saying that a chef will still produce a chocolate cake even if he decides to include chicken, tomatoes and onions in the mixture. Clearly, the assessment of risk in mental health decision-making is in no way analogous to the process of identifying the ingredients in a recipe.

Yet, Glover-Thomas' recipe analogy is not wide of the mark. Instead of having to go through a formalistic process of identifying specific pre-determined ingredients which may culminate in a recipe of risk, it may be that mental health practitioners are simply *connoisseurs* of risk. Like a pastry chef with a tacit understanding of what makes a good chocolate cake, it may be that psychiatrists are highly attuned to patients' risks. In other words, they just know a risk when they see one. For that reason, there is no need for the law to define 'risk' nor do mental health practitioners need to recognise anything as

formalistic as a recipe or catalogue of ingredients. As Glover-Thomas later contended, decision-makers' 'gut instinct' can play a significant role in mental health practice and this 'stems largely from professional experience and...context.'⁸⁴ This suggests that mental health practice relies to some extent on intuitive and unarticulated responses by decision-makers which defy legalistic explication. If this is the case, then it is not true that 'anything goes' – not because the law prescribes and narrows decision-makers' focus, but because practitioners comply with a kind of tacit self-denying ordinance.

Under a New Medicalist framework like the 2007 Act, the law is intended to play a less determinative role in the decision-making process. However, mental health law and policy's retreat from legalism has not triggered a descent into anarchy; what is keeping things consistent? It is submitted that decision-makers possess *tacit knowledge of what risk is and the factors that are probative of it* for the purposes of the MHA's compulsory powers. Despite the lack of a statutory definition of the concept, decision-makers' tacit knowledge of risk maintains consistency and certainty under the MHA. This sort of spontaneous order has emerged quite independently of, and is impervious to, the law's prescriptions.

According to Michael Polanyi, 'we know more than we can tell'.⁸⁵ This is because there are two kinds of knowledge: one is 'explicit' and is typically codified and transferrable; the other is tacit and less amenable to articulation and communication.⁸⁶ It is this dichotomy which means that we may know and recognise a person's face in a crowd (explicit

⁸⁴ Glover-Thomas, *supra* n.69, at p599.

⁸⁵ M. Polanyi, *The Tacit Dimension*, London: Routledge and Kegan Paul Ltd., 1967, at p4.

⁸⁶ *Ibid.*

knowledge) without being able to explain *how* (tacit knowledge).⁸⁷ In Polanyi's view, any activity which depends on a person's skill or artistry in order for it to be done well necessarily requires the performer or artist to possess tacit knowledge of it. He argued, for example, that a particularly skilful golfer relies on his explicit knowledge of certain 'maxims' (i.e., the rules of the game) and his tacit knowledge of his art.⁸⁸ A golfing novice may learn the rules of the game explicitly and thereby gain an insight into how it is played, but he cannot internalise the skills necessary to become a professional in the same way. This tacit dimension must also explain how an inexperienced cook can follow the same recipe for a chocolate cake as a pastry chef and yet bake a cake of a vastly different quality. It is one thing for a person to know the rules of a particular game or art but quite another for him to play or do it well.⁸⁹ There is also something intangible about tacit knowledge: a concert pianist has 'subsidiary awareness' of his skill, meaning he can do it well without necessarily thinking about it; as soon as he brings the actions of his fingers within the realm of his 'focal awareness' he may not be able to continue playing to the same standard.⁹⁰ Polanyi thought that the same principles apply equally to connoisseurship, contending that 'the skill of testing and tasting is continuous with the more actively muscular skills'.⁹¹ Consequently, a person can only become an expert wine-taster or pastry chef by generating a vast amount of experience, often under the guidance of a master.⁹² As a rule of thumb, if an art or skill

⁸⁷ *Ibid.*

⁸⁸ M. Polanyi, *Personal Knowledge: Towards a post-Critical Philosophy*, London: Routledge and Kegan Paul Ltd., 1958, at pp30-1, 49-50.

⁸⁹ *Ibid.*

⁹⁰ *Ibid.*, at p56.

⁹¹ *Ibid.*, at p54.

⁹² *Ibid.*, at p55.

cannot be specified in detail it cannot be transmitted by prescription and therefore relies on tacit knowledge to be done well.⁹³

Interestingly, Polanyi thought that the same principles apply to medical practitioners, whose skills depend as much on the art of *doing* as they do on the art of *knowing*.⁹⁴ He argued that doctors are essentially *connoisseurs* who must learn to recognise certain symptoms as indicators of disease or infirmity in accordance with their tacit knowledge. It is not enough for doctors to possess explicit knowledge of various conditions or diseases; they also ‘must personally know [a] symptom and...learn [it] by repeatedly being given cases for auscultation in which the symptom is authoritatively known to be present’ and compare it with cases in which the symptom is not present until they can prove their knowledge to their masters’ satisfaction.⁹⁵ Medicine therefore relies on the same kind of connoisseurship as wine-tasting because in neither case has it been possible to replace an expert’s assessment with a ‘measurable grading’ capable of helping laypeople to reach the same conclusions.⁹⁶ Doctors’ expertise improves the longer they are in practice through a process of trial-and-error which ultimately heightens their professional instincts and grows in accuracy. For that reason, Polanyi criticised the scientific tendency to insist on the introduction or maintenance of an ‘objectivist framework’ which would play down the ‘real and indispensable intellectual powers’ of decision-makers.⁹⁷ He objected to any attempts to specify or enumerate particulars in fields which depend on tacit knowledge, arguing that the

⁹³ *Ibid.*

⁹⁴ *Ibid.*, at p54.

⁹⁵ *Ibid.*, at p55.

⁹⁶ *Ibid.*

⁹⁷ *Ibid.*, at pp16-7.

damage done by such specification ‘may be irremediable’ because it seeks to replace that knowledge with something much less nuanced.⁹⁸ Indeed, Polanyi thought that attempts to codify knowledge which exists tacitly would be ‘self-defeating’ because too keen a focus on particulars would mean that decision-makers would lose sight of their essential function.⁹⁹ Presumably such attempts at codification would also deprive doctors and other specialists of the use of the full range of their expertise, thereby working counter-productively. Implicit in Polanyi’s description of tacit knowledge is the assumption that experts simply know better than others and there is no substitute for this knowledge. If we deny it exists or seek to marginalise its role, we deprive patients (amongst others) of the indisputable benefits of a specialist’s expertise.

It is submitted that Polanyi’s idea of tacit knowledge applies to mental health practitioners’ assessments of risk under the MHA. There are compelling parallels between the way these decision-makers assess and interpret patients’ risks and the way Polanyi believes a connoisseur develops his expertise. The notion that decision-makers simply *know* what amounts to an actionable risk, in the same way a pastry chef knows what makes a good chocolate cake, is a much more forceful analogy than the idea of there being a ‘recipe’ of risk with a fixed set of ingredients. Risk is not a species of explicit knowledge; the concept is neither codified nor transferrable. We have seen that there is no definition of ‘risk’ in the MHA, no understanding of the concept among practitioners capable of abstract articulation, and no wording which might capture its entire essence. Consequently, mental health practitioners have to develop tacit knowledge of what a risk is and what factors might be

⁹⁸ Polanyi, *supra* n.85, at p19.

⁹⁹ *Ibid*, at p34.

indicative of the presence (or absence) of such a risk. This requires a high degree of professional skill which cannot be imparted simply by telling a layperson how it is done. It is not enough to say 'It is a risk when X applies' because X may apply in other contexts and the patient may not be deemed to pose a risk. Mental health decision-makers are therefore connoisseurs who are able to conclude that a patient poses a risk to himself or other people without necessarily being able to explain why or how they have reached that conclusion. This is not to say they are clairvoyant or possess a sixth sense; they simply develop such a finely-tuned and intrinsic awareness of the indicators of risk that they may only be able to justify a decision on the basis of a hunch or a bad feeling. Indeed, Polanyi believed that doctors' expertise comes from the same sort of connoisseurship extant, *mutatis mutandis*, among wine-tasters, golf pros or pastry chefs; it is therefore not a great leap for us to apply his thinking to psychiatrists, AMHPs and other professionals too. Understanding risk for the purposes of the MHA therefore relies on decision-makers' tacit knowledge if it is to be done well. By extension, it must be the case that attempts to define risk or particularise its content would be as counter-productive as Polanyi thought it would be in relation to other sciences. We have already seen that it is impossible to draft a statutory definition of 'risk' capable of capturing the essence of the concept for the purposes of the MHA. Even if it were possible, Polanyi's argument would suggest that such an intervention in the domain of mental health professionals would diminish the significance of their expertise and thereby undermine the value and purpose of their involvement in the decision-making process. The legalistic impulse to define and delimit would prove highly destructive in this field.

If one accepts that the 2007 Act was based on the philosophy of New Medicalism, it must be the case that decision-makers' tacit knowledge of risk has played a role in

maintaining a fairly consistent rate of admissions since the amendments came into force. While it is certainly true that the 2007 Act's reforms sought to facilitate mental health services' control over patients with mental disorders, there is no evidence to suggest that this has had the effect of jeopardising liberty because of the law's looser constraints. There is also no evidence that the policy emphasis placed on risk has had a lasting effect on decision-makers' application of the concept in practice. Although the MHA's determinative potential has become less significant, mental health decision-makers have continued to understand and interpret risk according to their expertise. Risk is and always has been a matter of fact for the 'connoisseurs'; the law has had no effect on how the concept is applied. Indeed, Polanyi's argument would suggest that the law should never attempt to have such an effect. As difficult as it is for lawyers to accept, it seems that law is not always the answer.

4. Conclusions

The 2007 Act revives medicalism in English mental health law. This is not the same conventional medicalism which shaped the 1959 Act. The emphasis is now on regulating the risks that patients with mental disorders can pose. For that reason, the 2007 Act can be said to embody a distinct philosophy, New Medicalism, in which the MHA facilitates decision-makers' regulation of these risks. While it attracted a great deal of criticism prior to and following its introduction, we have seen that the 2007 Act has not realised the worst fears of its critics.

There are two reasons for this. First, New Medicalism is pragmatic. Mental health decision-making requires practitioners to operate in an uncertain domain. Psychiatry is an

inexact science. Mental disorders manifest themselves in different ways. Some – though by no means all – patients will pose risks to themselves or other people. The advantage of New Medicalism is that it generates a statutory framework which takes account of these uncertainties. Risk is an essential component of the framework. It is also a vital tool for managing uncertainties. As troublesome as the concept can be from a legal point of view, risk has much to recommend its inclusion in the MHA. Indeed, it is an inevitable and irreplaceable feature of any legislative framework which seeks to pursue the legitimate objective of protecting patients and the public from the harm that may be caused by those suffering from mental disorders. There is no alternative mechanism capable of replicating risk's effectiveness in that regard.

Secondly, New Medicalism treats risk as a matter of fact which is properly reserved for mental health practitioners. It is impossible to define 'risk' in a way that would capture the entire range of the concept's application to mental health practice. And even if it were possible, it would be undesirable for such a prescription to constrain mental health practitioners. Risk's great advantage is its flexibility and malleability. As we saw in chapter four, the emphasis on risk in mental health policy prior to the introduction of the 2007 Act in no way adversely affected the dynamics of decision-making. The reason for this is that decision-makers have tacit knowledge of what risk means. They are 'connoisseurs' who develop an innate sensitivity to patients' risks and respond according to their working constructions of the concept. This knowledge can neither be codified nor transferred to other people. While it may not satisfy the lawyer's quest for legalistic purity, it seems that this tacit knowledge of risk culminates in a reasonably effective and consistent

interpretation of the concept for the purposes of the compulsory powers. Law is therefore not always the answer.

Conclusions

Laws governing the compulsory care and treatment of people suffering from mental disorders represent another front in the battle between the sometimes competing interests of liberty and security. Where should the law strike the balance between maximising the freedom of people with mental disorders and protecting the community from the actions of a risky minority? The Mental Health Act 2007 ('2007 Act') is the first major reform of English and Welsh mental health law in the 21st Century. Its amendments to the Mental Health Act 1983 ('1983 Act') theoretically make it easier for decision-makers to recommend that a person with mental disorder be detained in hospital for the purposes of receiving care and treatment. In the battle between liberty and security, the 2007 Act might be said to tip the balance in favour of the latter.

There are two reasons for this. First, the 2007 Act was the product of a policy agenda which made no secret of its desire to regulate patients' risks in order to prevent, or at least reduce the impact of, adverse outcomes like suicide or homicide. Policy-makers insisted that the level of risk which people with mental disorder pose to themselves or other people should dictate when compulsion is indicated and explicitly rejected capacity-based and health-focused alternatives. Secondly, the 2007 Act diluted the determinative power of the law by placing the interpretation of the admission criteria firmly in the realm of practitioners' discretion. It simplified the definition of 'mental disorder'¹ and introduced the 'appropriate treatment' test,² thereby bringing a wider range of people within the ambit of

¹ 1983 Act, s.1(2).

² 1983 Act, s.3(2)(d).

the compulsory powers. It also failed to define 'risk' or delimit the factors that might be probative of it, despite the renewed prominence the policy discourse gave to the concept. In this way the 2007 Act is unlike any of its predecessors: it is neither a product of legalism because it dismantles the legalistic prescriptions governing mental health decision-making, nor is it an example of 'conventional' medicalism because it does not prioritise professional discretion for the sake of improving health outcomes. Instead, the 2007 Act is the product of a distinct philosophy, which prefers a reduction in the determinative power of mental health law in order to broaden decision-makers' discretion and enhance their responsiveness to patients' risks. We have called this philosophy 'New Medicalism'.

This thesis has sought to establish whether the 2007 Act has jeopardised patients' liberty and facilitated control by mental health services. It has sought to make an original contribution as a piece of socio-legal scholarship by combining theoretical and doctrinal analyses with relevant discussion of practical matters. It has hypothesised that the New Medicalist paradigm has reduced the determinative power of the law to such an extent that mental health decision-making is now characterised by uncertainty and inconsistency. It has assumed throughout that the normative constructions of 'jeopardising liberty' and 'facilitating control' are two sides of the same coin; i.e., a statute which facilitates control by mental health services must also jeopardise patients' liberty. In reality, it is too simplistic to characterise the impact of the 2007 Act in this way; while it may have facilitated control, there is no evidence to suggest that it has also jeopardised liberty.

That the 2007 Act sought to facilitate control by mental health services over 'risky' people suffering from mental disorders is not really in dispute. The regulation of risk is central to the New Medicalist paradigm. In chapter two, we examined the works of Ulrich

Bech, Anthony Giddens and Michel Foucault to find a suitable theoretical template which might enable us to account for the rise of the risk agenda in contemporary mental health policy. While there are interesting parallels between Beck and Giddens' theories and mental health policy in general, Risk Society does not apply comfortably to the renewed emphasis on risk where the MHA's compulsory powers are concerned. Instead, the Governmentality thesis offers the most compelling model here, casting risk as an instrument of social control to be deployed to root out 'deviance' in the social order. When viewed through this prism, we begin to understand the motives that drove the 2007 Act: a section of the population fails to conform to certain 'regularities' and is therefore needful of control and discipline. The 2007 Act in this way lends itself to deconstruction through the deployment of a Foucauldian analysis.

The 2007 Act's emphasis on risk also has practical consequences. In chapter three, we saw that risk is a highly problematic concept from a legal point of view. The MHA has never defined 'risk' and the courts avoid any incursions into the clinical domain which might inhibit decision-makers' discretion. For that reason, what the concept means in the abstract and how it should be interpreted are unclear. Risk is a matter of fact reserved for decision-makers, meaning that people with mental disorder are unable to predict how they might be assessed by their clinical team. They are at the mercy of decision-makers' potentially esoteric and abstruse interpretations of risk. For that reason, the potential for arbitrary or excessive decision-making beyond the reach of judicial oversight is significant. By raising the prominence of risk in this way, the 2007 Act and its surrounding policy have clearly facilitated control by reducing the law's determinative power.

Yet, has the 2007 Act's actually jeopardised patients' liberty? Three things define the post-2007 Act era. First, record numbers of people with mental disorders were compulsorily admitted to hospital in three out of the four years since the 2007 Act came into force. Secondly, more patients are now detained in hospital at any given time than has ever been the case in the history of civil commitment in England. Thirdly, fewer patients are now subject to informal arrangements than was the case five years ago. The introduction of the 2007 Act has therefore coincided with an increase in the use of the compulsory powers and a decline in non-MHA care and treatment strategies. If one were to ask whether the post-2007 Act era is characterised by less liberty for people with mental disorder, the answer is plainly yes. Yet the reality is much more subtle: this thesis has examined whether the *2007 Act* specifically and its *policy emphasis on risk* have led to increased controls over and fewer freedoms for patients with mental disorder; in other words, is there *causation* as well as a *correlation*? Here, the answer is more equivocal. The long-term admission statistics show that the number of compulsory admissions in the post-2007 Act era conforms to a trend that began in the mid-1980s. There has been no increase in the *rate* of admissions since the 2007 Act came into force. There is therefore no apparent connection between the change in the law and the record number of compulsory admissions. The available empirical evidence also shows that mental health decision-makers were largely unmoved by the 2007 Act's reforms and continue to assess and interpret risk in the same way that they did under the original 1983 Act.

Reforms to mental health statutes do not always achieve their policy objectives and, when they do, the effect is short-lived. Decision-makers' knowledge of the rules that govern their professional responsibilities can lack accuracy and their application of the law can be

imprecise. Far from serving as the ultimate authority, the law appears to be one factor out of many that decision-makers may consider – and perhaps even deliberately ignore. When considered against this backdrop, the 2007 Act's negligible impact should not come as a surprise. The law is simply not as determinative as the assumptions about its role might imply.

The 2007 Act is not *directly* responsible for the current situation in which there may now be more control of, and less liberty for, patients with mental disorder. Many of the problems that arise from the divergence between law and practice are long-standing. The problem with the concept of risk discussed in chapter three continues under the 2007 Act. So too do broader issues like the law's failure to complete policy objectives and decision-makers' poor knowledge and application of the rules. There is no evidence that the 2007 Act has exacerbated these problems. By dismantling the original 1983 Act's legalism, the 2007 Act's reforms have retrospectively legitimised established decision-making practices; i.e., the law has followed rather than led.

This means that far from instituting authoritarian or illiberal decision-making practices, the 2007 Act and its New Medicalist policy agenda may have much to recommend them. Some – though by no means all – patients will pose risks to themselves or other people. The advantage of New Medicalism is that it generates a statutory framework which takes account of this uncertainty. Risk is an essential component of the framework. As troublesome as the concept can be from a legal point of view, risk has its uses for the purposes of the MHA. Indeed, it is an inevitable, irreplaceable and historically-invariant feature of any legislative framework which seeks to pursue the legitimate objective of protecting patients and the public from the harm that may be caused by those people

suffering from mental disorders. There is no alternative mechanism capable of replicating risk's effectiveness in that regard.

It is impossible and undesirable to define 'risk' in a way that would capture the entire range of the concept's application to mental health practice. Risk's great advantage is its flexibility and malleability – although this is something of a double-edged sword. Decision-makers have tacit knowledge of what risk means. They are 'connoisseurs' who develop an innate sensitivity to patients' risks and respond according to their working constructions of the concept. This knowledge can neither be codified nor transferred to other people. This thesis has shown that professionals' expertise may do more to maintain consistent and certain decision-making practices than any statutory provision ever could. While it may not satisfy the lawyer's quest for legalistic purity, it seems that this tacit knowledge of risk culminates in a reasonably effective and consistent interpretation of the concept for the purposes of the compulsory powers.

This project's initial hypothesis reflects the assumption that an emphasis on risk and an expansion of the scope of compulsory mental health legislation must inevitably lead to an increase in the number and rate of detentions. It is true that the 2007 Act certainly sought to achieve a more robust statutory framework which could more readily regulate patients' risks in the interests of protecting the public. Yet, there is no evidence that the 2007 Act has had its intended effect. The law may now be in line with practices which emerged quite independent of its prescriptions some time ago. It is hoped that the findings of this thesis will inform the policies which drive reforms to mental health laws in the future – if only by lessening the emphasis on the law's capacity to make a difference in this field. While the

2007 Act clearly sought to facilitate control, there is simply no evidence to suggest that it has led to the sort of uncertainty and inconsistency which might jeopardise patients' liberty.

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