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The Age of Risk: Risk Perception and Determination Following the Mental Health Act 2007

Risk Perception and Determination

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Abstract Reforms to the mental health law framework for England and Wales, which were introduced by the Mental Health Act 2007, are now having a practical effect on day-to-day mental health decision-making. The 2007 Act amends the Mental Health Act 1983, which governs the compulsory hospitalisation and treatment of people with mental disorder; and represents the culmination of a protracted and controversial reform process which has spanned much of the last 15 years. One of the key foci in the 2007 Act is the question of the risk posed by the patient, primarily to others; a result of both the social and political impetus behind the reform process and mounting public anxiety at the management of the mentally disordered. The new Act seeks, as with past legislation, to find the elusive balance between protecting and facilitating the individual's autonomy while also providing an effective framework for the wider public right to protection. The 2007 Act solidifies the dominance of risk by providing a legitimating framework in which risk can be assessed, monitored, and managed. This attitudinal change is demonstrated by the gradual and almost insidious adoption of risk terminology within the practical decision-making setting and the increasing use of risk assessment and management tools. This article is informed by an empirical study which examined individual professional and institutional responses to the mental health legislation in relation to risk. It examines whether the amended legislative framework amplifies risk as an increasingly dominant concern within decision-making. The paper then goes on to consider how decision-makers use risk to assist with their daily roles. Extrapolated from data obtained through the study, several models of risk determination are then discussed. Finally, some thought is given to whether the extension of the risk concept has the potential to become more fundamental within the organisation and legitimisation of mental health care.

Keywords: Mental Health Act, risk, decision-making processes.

I. Introduction

Mental health decision-making has always entailed an element of risk assessment. Over recent decades it has featured more prominently in the mental health legislation of England and Wales.[1] Successive legislative frameworks have reflected the practical reality of risk evaluation and its determination, albeit in a fairly oblique manner. However, following the Mental Health Act 2007, risk assessment and management have become explicit concerns of the civil commitment process. Consequently, a patient's risk either to self or others necessarily plays a significant part of the mental health decision to engage the civil commitment procedures.[2] Yet, the mental health legislation neither defines risk nor delimits the factors relevant to it, and this forms the basis for many difficulties. While soft law, such as the Code of Practice[3] and generic NHS Trust Clinical Risk Assessment Tools,[4] provide some guidance, what constitutes a risk to self or others is a matter for decision-makers alone. How reliable, valid, and professionally rigorous risk assessments may be is unclear. Bartlett contends that some decision-makers 'operate on a personal and ad hoc system of interviewing, based on their own experience of what patients have turned out to be dangerous in the

past'.[5] This approach to risk prediction and determination raises some grave challenges for those working within the mental health system and for those regulating and scrutinising the operation of the legislation, not least the problem that any system of risk assessment and management cannot be wholly accurate.[6]

For mental health decision-makers, clinicians, and social workers, the risk agenda means that in practice they must endeavour to strike a balance between their patients' personal freedoms and the public's safety. The purposive character of the mental health legislation emphasises that decisions should be taken with a view to minimising the undesirable effects of mental disorder, by maximising safety and well-being.[7] In theory, risk provides a facilitative tool with which decision-makers may achieve this balance, i.e. by deploying the compulsory powers under the Mental Health Act where a patient's level of risk becomes so great that he or she poses a threat to either self or others. However, this is necessarily a subjective process and one that is prone to inaccuracy and inconsistency.

In order to compulsorily admit a person suffering from mental disorder to hospital, two registered medical practitioners must certify that he or she poses a threat to self or others.[8] A patient must suffer from a mental disorder as defined by section 1 of the Mental Health Act 1983[9] in order for decision-makers to engage the compulsory powers. The standards which the compulsory criteria require are ambiguous [10] and as such, decision-makers enjoy a wide discretion to interpret relevant factors according to their professional judgment. Sections 2(2)(b) and 3(2)(b) presume that decision-makers will assess a patient's level of risk, although the provisions neither use the term 'risk' explicitly nor delimit the scope of material considerations which might apply. Risk is an open-ended construct for decision-makers to assess and interpret in accordance with their professional judgment and experience.

The existing jurisprudence and the considerable work of socio-legal theorists in this area have done little to clarify these issues.[11] It is clear that simply restating the statutory criteria will not justify a decision-maker's admission of a patient under the Mental Health Act,[12] yet neither the Act nor attendant case law disclose '*what*' factors might count towards satisfying the same criteria, and within this how an evaluation of risk of harm might be determined. Similarly, decision-makers may interpret the phrase 'nature or degree' separately-- where a mental disorder is of a nature warranting detention under the section, but not of a sufficient degree, admission may still be legitimate.[13] As such, where a patient's disorder is at risk of deterioration though has not yet reached this critical point, the patient can be detained on the basis of the nature of the disorder, even though the degree of the disorder is not yet sufficient to warrant intervention.[14] As discussed below, the determination of risk within given commitment provisions is also handled by decision-makers as a divisible concept, whereby risk is not seen as serving as a universal measure in mental health practice; but rather, the concept is divisible depending on the context in which it is deployed. These interpretations are hardly surprising given the need for pragmatism in mental health practice. Yet what this broad discretion invites is a more pervasive influence of risk within the decision-making process; unfortunately, the lack of clear definitional parameters surrounding risk presents concerns about just how far risk will be perceived and determined.

Rose argues that the language of risk seems 'all-pervasive' in mental health practice; an observation which has even more pertinence in the more challenging post-Human Rights Act 1998 mental health environment.[15] This is unsurprising. In many ways, risk determines the nature, duration, and extent of a patient's engagement with the mental health services,[16] and a patient's risk profile determines the level of any supervision in the community.[17] The significance of risk's socio-political influence as a policy driver increased during the 1990s and throughout the lengthy period of mental health law reform. Fennell argues that successive governments have pursued a 'public safety agenda' in response to concerns 'about homicides by mentally disordered people'.[18] This political discourse has infused public policy and mental health law with the risk agenda. While the Richardson Committee recommended that capacity and autonomy be at the heart of mental health law,[19] the Labour Government prioritised public safety 'in determining the question of whether compulsory powers should be imposed'.[20]

This paper is informed by data obtained in interviews conducted with individuals employed by Mersey Care NHS Trust, all of whom were involved in mental health decision-making either directly (decision-making affecting individual cases) or indirectly (decision-making affecting institutional and organisational design).[21] The main objectives of this study were 2-fold. First, given the growing political emphasis on the risk agenda and the breadth of interpretive scope within the Mental Health Act 2007, the study sought to gain a clearer understanding of how risk was perceived and interpreted by mental health decision-makers working under the governance of the Mental Health Act 2007.[22] Secondly, the study sought to identify the impact of risk on the civil commitment procedures by investigating decision-makers' experiences following the 2007 Act. In particular, focus was placed upon the nature and extent of risk in decision-makers' fulfilment of their legal responsibilities and how risk influenced decision-making, if at all. This paper shares some of the findings of the study and examines current perceptions of patient risk-profiles, the influences of socio-political trends towards risk assessment and its management and how this is transposed into decision-making

in practice.

II. The understanding of risk and its determination within the clinical mental health setting

A. Difficulties of Definition

When examining NHS Trust organisational clinical risk assessment tools, it quickly becomes clear that 'risk' is both a nebulous and fluid conception; and something negative that is to be avoided or minimised. Determining risk is initially a hermeneutic exercise. It then becomes a process of transposing this interpretive problem into something which offers a practical structure (within a statutory framework). This is by no means an easy exercise, particularly when the decision-maker within the mental health context rarely has a legal background. For example, the process of risk assessment is often an 'estimation of risk potential based on ... [an] ... understanding of the presence and relevance of certain conditions that ... [are] ... assume[d] to be "*risk factors*" and the absence of certain other conditions that ... [are] ... assumed to be "*protective factors*"'.[23] Likewise, efforts to define risk are often formulated in terms of the function of the process. This functionalist stance recognises the risk determination process as being one which can '*prevent*' hazardous outcomes from occurring, or at least to '*reduce*' and '*minimise*' the impact of such risk on others. Indeed, clinical risk assessment tools are generally couched in language that focuses on '*negative*' outcomes, such as the risk of violence to others or the risk of an individual neglecting himself; which, in turn, then gives the appearance that risks associated with a diagnosis of mental disorder are best avoided.

These NHS Trust definitions seek to position the particular organisation apropos the conception of risk within an abstract sphere of possible risk assessment and management protocols; for example, the institution's position on personality disorders will feed into the daily decision-making processes of the individual professional. Such broad brush definitions seek to define what the risk is, to the extent that risk is deemed a legitimately acceptable consideration in the decision-making process, yet leave sufficient scope for wide professional discretion in individual cases.

Unfortunately, while such definitions clarify the '*abstract*' concept of risk, what actually constitutes a 'risk factor' '*in practice*' is left to the discretion of decision-makers to determine in accordance with their professional judgment and experience. The Mental Health Act neither defines risk nor delimits the scope of factors pertaining to it. This highlights a tension between promoting a degree of pragmatism, essential to mental heath practice by not prescriptively fettering decision-making, and providing clarity in such decision-making through prescriptive, and consequently easily predictable, criteria. Moreover, clear criteria also promote more effective rights protection. ... The European Court of Human Rights (ECtHR)[24] recognised that flexibility is essential, but, where individual liberties are at stake, deprivations of rights should not result from administrative discretion or be arbitrary in any way.[25]

It is perhaps telling that without a clear definitional guide under the 2007 Act, there was a significant variation in the meanings attributed to risk by decision-makers in the research sample. The prevailing attitude was that a patient's risk to self (including risk to health) or others provides the primary basis for all mental health decision-making, but, despite this central role of risk in the decision-making process, all participants admitted that there was no comprehensive definition of the concept with which they worked. It was anticipated that this divergence in the understanding of risk might be more evident among particular professional groups owing to the different professional perspectives and agendas. In fact, no evidence of this emerged from the study; rather, it found that definitions of risk did not alter according to a decision-maker's background--there was no connection evident between a decision-maker's professional background, experience, or environment (for example, hospitals or community-based facilities) and his or her definition of risk. This was a counter-intuitive finding and one which can be explained in several ways, though a likely explanation would be the strong professional relationships that exist within the mental health context. The statutory decision-making framework requires effective joint working to enable decisions to be made and duly processed; in the research sample, the strength of these relationships was particularly evident, offering the potential for a blurring of traditional professional boundaries.

It appears that decision-makers apply self-authored 'working definitions', which appear somewhat esoteric and abstruse. For example, it was noted by one participant that '... risk is ... a slightly wide version of safety'. Often the decision-maker's understanding of the conception of risk was tautological and, predictably, a definition of risk representing a rephrasing of the statutory criteria was common among the sample. Of greater concern, some professionals appeared to read provisions into the Mental Health Act that simply do not exist. One participant, for example, noted that defining risk under the legislation involves a distinction between 'risk of harm' and 'risk of dangerousness' and that these '... [have] ... two different meanings within the Act'.

B. Professional Perceptions of 'Risk'

Castel defines risk management as 'the identification, assessment, elimination or reduction of the possibility of incurring misfortune or loss'. In his view, risk has 'become an integral part of the professional responsibility of all those involved with psychiatry'.[26] The psychiatrists interviewed as part of this study demonstrated the truth of Castel's definition and assessment of risk. There was a clear recognition that risk is an integral part of the decision-making process under the Mental Health Act; with clinicians often responding to perceived risks depending on whether they are deemed 'dynamic', 'static', 'acute', or 'chronic'. They classified risk factors in this way to distinguish historical (static) and future (dynamic) trajectories of a patient's condition:

> (i) static risk factors relating to historical events which cannot be changed or reversed, for example, the age at which the first violent act occurred; and
>
> (ii) dynamic risk factors that can and often do change over time, for example, substance misuse, housing arrangements, and support networks.

The assessment of risk seeks to determine the probability that an adverse event will occur at a given point in time. The changing nature of a patient's profile means that assessment is necessarily an ongoing and evolving process, which in turn becomes part of a continuum of care and treatment. Different factors can increase or decrease a patient's level of risk.[27] Such factors can include:

- dysfunctional family background;
- non-compliance with medication;
- low socio-economic circumstances;
- difficult temperament;
- low living standards;
- community problems;
- low self-esteem; alcohol or substance use; and
- previous trauma.

Some risk factors may act as protective mechanisms. For example, the responsibility attendant on raising a family may dissuade a service user from acting on suicidal ideation. In consequence, it is clear that decision-makers will often have to go beyond the 'clinical' when assessing and determining risk. This 'beyond clinical' approach to risk assessment is very functional in character, and mirrors the Department of Health's risk framework, published in 2007.[28] This guidance relates to three areas of risk: violence (including anti-social and offending behaviour); self-harm or suicide; and self-neglect.

Given that the objective of risk management is to find a way of 'reducing the risk of harm occurring and increase the potential for a positive outcome',[29] it is expected that a decision-maker will, in the first instance, decide how such risk might become acute and what triggers this: 'The process involves identifying and describing the predisposing, precipitating, perpetuating and protective factors relating to the risk, and how these might interact to produce an increase or decrease in level of risk'.[30]

The Department of Health recommends that every risk formulation should have attached to it a plan that makes clear what should be done if and when warning signs become apparent. Nevertheless, despite the operation of a 'harm-reduction model'[31] that is designed to tackle risks, interviewees were generally unwilling to offer clear examples of factors that they '*would*' regard as '*almost-always*' pointing to risk in practice. It is contended that this reticence stems largely from the concern that such a step could fetter future professional discretion.

The central problem with the pragmatic approach identified above is that it bears little relation to the formal legal

provisions. Indeed, it may compromise patient safeguards by relying so heavily on a high degree of professional discretion. When this is placed within the socio-political context, decision-makers may feel compelled to construct a risk profile before deciding whether evidence indicates the need for a compulsory detention response, particularly for those patients with a long and tempestuous psychiatric history. In seeking to strike a balance between the need to ensure adequate governance of decision-making, on the one hand, and recognising that risk determination 'is not a science' and has an 'organic quality', on the other hand, decision-makers face potentially intractable tensions.

An observation by a psychiatrist within the research sample was that risk was often deemed to be 'the possibility of adverse incident[s] of harm coming either to a person or to others', which suggests that decision-makers must seek to quantify the probability of hazards occurring. Whether the risk agenda is gently shifting the rationale of mental health decision-makers remains an open question. If, indeed, risk has distorted the decision-making process, some serious implications may ensue. Of particular concern is the question whether risk is now displacing other considerations in decision-making? Kempsell *et al*. acknowledged as far back as 1997 that, social and medical services '... at both a policy and practice level are increasingly focused on issues of risk. [It is postulated] ... that risk assessment, risk management, the monitoring of risk and risk-taking itself are rapidly becoming the dominant raison d'être of such agencies, thus supplanting ideologies of meeting need or welfare provision'.[32] This attitudinal revolution has been demonstrated by the adoption of risk terminology within the practical decision-making setting and the increasing use of risk assessment and management tools.[33]

This notion that risk is self-evident was pervasive amongst many of the research participants. As identified above, several psychiatrists restated or paraphrased the statutory admissions criteria when asked to define risk--a tendency that may be termed the 'risk is risk paradox', in which decision-makers define the concept circuitously without any elucidation of which factors actually constitute risk.

Despite risk's open-ended quality, one research participant hypothesised that if one hundred patients, hitherto unknown to mental health services, presented before one hundred sets of gatekeepers, they would all come to the same conclusions. This belief was drawn from the notion that practitioners' professional imperatives would ensure that the concept of risk generates consistency in the aggregate. Although the concept lacks certainty, the research participant considered that decision-makers' outcomes are self-regulating and so dictated by an internal governance system. However, this conflicts with existing research undertaken by Peay, which suggests that mental health decision-making by teams of joint-decision-makers is neither consistent nor predictable, but is instead arbitrary and uncertain:[34]

[I]t is readily apparent that whilst the facts of [a patient's] circumstances may remain the same, their interpretation will depend very much upon the individuals who are required to assess him. Or, whilst 'no two cases are the same'; no single case is likely to look the same to any two individuals.[35]

Crucially, in tandem with the belief that risk was deemed a largely unrestricted paradigm, just under half of the sample also believed that the Mental Health Act 2007 introduced a broader definition of risk distinct from the detention criteria. This is erroneous, as a definition of risk is omitted within the legislation. Fifty-eight per cent of the sample interpreted the law in a way which presupposes that considerations of risk occur in isolation, separated from the Act's detention criteria. While this may be the case in practice (when dealing with non-compulsory patients, for example), this distinction between the risk concept and the detention criteria reveals a disconnection between the legal requirements and practical necessity.

The task of finding an effective equilibrium between patient rights to liberty and meeting the public protection agenda is necessarily difficult, yet several psychiatrists acknowledged that at times their own professional discretion was also fettered by the wider influence of public policy.[36] Sometimes admitting a patient to hospital is not clinically justifiable though maintaining them in the community presents significant dangers, if mishandled. Often psychiatrists who are based in Assertive Outreach Teams must consider both the 'short-term' risks, for example, the risk of harm to members of the public when the patient was not admitted, and 'long-term' risks, for example, the risk of irreparable damage to the therapeutic relationship following a patient's admission. Also, decision-makers operating in Assertive Outreach Teams[37] often work at a higher level of risk as patients tend to have chronic and enduring mental health difficulties which are often difficult to manage, yet they are cared for in the community. This particular type of service provision requires very careful management of patients, yet service providers often demonstrate a greater willingness to take positive risks[38] which might increase the risk of harm occurring in the short term but have a much greater therapeutic benefit to the patient in the longer term. Such decision-making is labelled positive risk taking, because the therapeutic benefit to the patient of a particular care and/or treatment decision is taken over and above all other risk concerns. On positive decision-making, one research participant indicated that risk-taking forms an integral part of a mental health decision-makers' process. It was explained that, for some cases, it necessitates decision-makers to take a long view. For instance, when a patient has a history of recurrent self-harming behaviour, often intervention is regarded as more likely to reinforce that behaviour; so a decision is made to step back from the

intervention. However, with the increasing public policy pressure on decision-makers to place risk of harm at the top of the agenda, they may become much more cautious in their interactions with patients which may ultimately jeopardise such positive risk taking approaches in the future.

From this, it is contended that the conception of risk does not serve as a universal measure in mental health practice but is, instead, seen as a divisible notion depending on the context in which it is deployed.[39] Instead of acting in a binary sense, risk may apply on different levels. Terms like 'significance', which were used frequently by all members of the research sample, possess no legal basis. ... They serve only to modify the concept of risk across a practitioner-constructed continuum. Moreover, the data suggest that decision-makers only intervene using the compulsory powers where risk goes 'above and beyond' a predetermined level, without elucidating what that level or limit might be. This raises concerns about the true purpose of the Mental Health Act: does it require that patients with a high risk profile be detained in hospital for assessment and/or treatment?[40] Or should it facilitate medical intervention for these patients in the community?[41]

This important question aside, risk has been and remains a fundamental and integral part of the process of mental health decision-making.[42] Many participants demonstrated the ubiquitous nature of risk--the fact that risk was generally recognised as the universal currency within mental health practice. However, while they claimed to be comfortable using the concept, their definitions of risk were, as identified above, either circular or lacked a convincingly legitimate and consistent application. For these reasons, 'risk' possesses wide semantic variation in mental health practice, encompassing both clinical (e.g. suicide ideation) and non-clinical factors (e.g. the patient's socio-economic background). This wide hermeneutic stance confers a freer hand on decision-makers, but it also promotes inconsistency and diminishes certainty in reaching decisions. Consequently, an individual subject to the mental health legislation may not know what his or her position is, or what it is likely to be, at any given point in the process. The net result of indistinct criteria and a lack of clarity in the implementation of the law is twofold: it potentially jeopardises individual patient rights, while also undermining public trust in the system as a whole. It should be made clear that research participants involved directly with patient care were all strongly motivated by their patient's welfare; they had an explicit awareness of 'rights' and the Human Rights Act 1998. However, the actual decision-making process, as explained by the interviewees, habitually appeared divorced from the broader rights-based statutory and jurisprudential mechanisms that exist to protect the rights of individuals.

The various interpretations of risk that emerged in this study stem from the concept's fluid character and the minimal guidance provided by the Mental Health Acts and associated soft law, such as the Code of Practice. The existence of such varying interpretations has potentially significant consequences. For those involved in making decisions with individual patients, the individual conceptions of risk they applied had considerable impact upon the outcomes for those patients. Perhaps of even greater concern, though, is the impact for those who make decisions at an administrative level, which can have a wider impact on the effective working of both the organisation and, ultimately, the mental health legislation itself. Such persons, often administrators and ex-clinicians with legal advice roles, who work at the margins of clinical activity, but are central to the clinical/legal interface are at the heart of the Trust's operations. Any erroneous interpretations of law by them have the potential to become embedded in the Trust's institutional framework. In-house training provision is an obvious avenue for this entrenchment of misunderstanding to take place. When coupled with evidence that these 'administrators' exhibited the same uncertainties about the definition of risk as all the other research participants, their roles could have the potential to influence the establishment of procedural norms within the organisation. March and Simon found that a decision-maker's organisational and social environment can often determine what consequences may be anticipated from a given decision.[43] From this, the organisational structure can also feed into alternative decision-making processes that take place.[44]

How risk is interpreted and applied within the practical setting will be likely to feed into the institutional training which will then create a self-fulfilling template of risk perception and responding management processes at a broader organisational and institutional level.

III. Models of risk determination in mental health

A. The 'Risk Recipe' Model

The study began with the hypothesis that decision-makers establish a patient's risk profile with reference to evidence of existing 'factors'; these then provide evidence to legitimise the use of the Mental Health Act's compulsory powers. Placing this hypothesis within a theoretical framework, Honoré's recipe model of causation in tort law is borrowed. Honoré posits that 'a cause is a necessary member of a set of conditions together sufficient to give rise to a given consequence'.[45] He argues that causing an outcome is analogous to 'completing' a recipe--the culmination of factors

or 'ingredients' generates a result.[46] In many ways, it is contended that this process mirrors mental health decision-making--a decision-maker will conclude that a patient poses a risk to self or others where the requisite combination of factors or 'ingredients' (both clinical and non-clinical) exists in his or her case. This may be termed the 'risk recipe' model.

To ascertain whether this 'risk recipe' model reflected mental health decision-making, two related issues were addressed during the interviews:

> (i) whether staff considered the 'risk recipe' model a fair representation of their decision-making processes; and, if so,
>
> (ii) which ingredient or combination of ingredients would lead decision-makers to the conclusion that a service user poses such a risk to self or others that it is necessary for him or her to be compulsorily detained under the Mental Health Act?

It has already been identified that the relevant ingredients that suggest a patient poses a risk to self or others are not defined by an exhaustive list of factors in the legislation or associated Code of Practice, but instead fall to be determined at an individual decision-maker's discretion. In this way, someone subject to the Mental Health Act may never be certain about which aspects of his or her diagnosis, characteristics, or circumstances a decision-maker has considered of material relevance. Decision-makers enjoy a largely free hand to identify and attribute weight to any factors that they believe are relevant to a patient's risk profile. The Mental Health Act's juridical framework then provides the scope to legitimise any potential arbitrariness that may flow from the decision-making process.

The 'risk recipe' model is limited in its application, particularly given the fact that a patient's risk profile is continually evolving and changing; with the assessment process being part of a continuum. Also, the presence or the absence of a particular factor from a patient's profile is not necessarily conclusive of risk in every case, as some risk factors can emerge and then recede depending on an individual's current mental state, his or her circumstances and a wealth of 'other' factors and triggers. For example, decision-makers may know that a patient with a diagnosis of depression with suicidal ideation will not act on the impulse, as he has not done so in the past just as a patient expressing no suicidal intent at all may kill him or herself. Some, if not all, factors are beyond absolute quantification--what level of suicidal ideation, for example, might be 'acceptable'; when does self-harming behaviour become 'dangerous'? It follows that the 'risk recipe' model is limited in its scope and cannot facilitate the creation of an accurate predictive framework, but it does serve as a useful illustration of the decision-making process.

The 'risk recipe' model was discussed with all the research participants in the study. The entire research sample, spanning the whole professional spectrum, accepted the model as a fair reflection of the 'mechanics' of decision-making; however, they were largely unwilling to be bound by a set of 'risk' factors which would evince risk in every case.

B. Too Many Cooks? Professional Responses to the 'Risk Recipe' Model

The concerns raised by participants related not to the 'risk recipe' model itself, but to the potential limitations of the model; namely, would the use of a fixed list of relevant factors have the potential to fetter professional discretion or hamper the ability of decision-makers to acknowledge and respond to the inherent nuances within mental health care?

On analysis, such concerns may be more theoretical in character than they first appear. Many interviewees (84%) did in fact acknowledge the presence of 'factors' that were fed into the decision-making process. First, risk was categorised as a product of 'acute', 'chronic', 'static', or 'dynamic' factors, followed secondly, by the recognition and pertinence of 'social' and 'occupational' factors within the process.[47] Therefore, both recognised clinical and non-clinical factors were often deemed to be either contributory to the risk of harm to self or others or protective against such risk. Approximately 26% of the interviewees were of the view that such a broad range of relevant factors means that the concept of risk does not lend itself to a rigid taxonomy which reflects the necessity that decision-makers must be free to attribute appropriate weight to the issues affecting each individual patient. Interestingly, this approach demonstrates a clear rejection of 'tick-box exercises'--risk assessments conducted using a universal pro forma--though this is precisely what is used to legitimise and corroborate compulsory detention decisions, thereby lending authority to institutional governance procedures.[48]

C. Relevant Considerations in Determining Risk

The overwhelming view of the research sample was that 'past behaviour' is regarded as the 'main predictor' of a patient's current risk profile. In addition, decision-makers must be aware of contextual factors, such as the effects of illicit substances and alcohol, particularly in relation to how these affect the patient's mental state. These factors, which feature in a patient's psychiatric background, are then fed into the overall risk assessment process. Hence, risk is 'organic' in character, determined by reference to context, personality, and current diagnosis; then an assessment is undertaken to evaluate how these interact. Throughout the research sample, research participants, particularly the psychiatrists, emphasised the primacy of clinical history. Some decision-makers believed that past incidents are largely conclusive of current risk; others took the view that previous encounters with mental health services cannot prejudice an assessment of the patient's current presentation. While this may simply be a matter of preference, the prejudicial impact of clinical history means that risk assessment is never wholly a value-neutral, fact-finding exercise. Many of the Approved Mental Health Professionals (AMHPs) interviewed concurred with this approach, acknowledging that the outcome of a risk assessment often depends on whether a patient is 'known or not known' by the mental health services--in other words, whether the individual has a psychiatric 'history'. Interestingly, the data suggest that where a service user had a history of contact with mental health services, this factor would ensure that they were much more readily engaged by those services again; 'history' is, therefore, a key 'ingredient' of the 'risk recipe'.

Clearly, reliance on an individual's psychiatric history is sensible as it represents a static variable within a sometimes quite turbulent patient profile. This approach is also reflective of institutionally approved systematic risk assessment tools. The HCR-20 is one of the most frequently engaged scale for psychiatric dangerousness prediction and half of the relevant considerations fall within the category of 'static' risk factors, such as the age at which violent tendencies first emerge. Despite the logic of relying on these types of factors, it opens up significant potential for discriminatory behaviour (whether intentional or unintentional) by the decision-maker, as these factors will be revealed each time a risk assessment process is undertaken. As Bartlett points out, '[p]sychiatric control begins to appear to be a life sentence'.[49]

In addition to the patient's psychiatric history, the decision-maker will then look into the current clinical factors that indicate a particular diagnosis within a broader non-clinical context. These dynamic risk factors can, and often do, evolve over time and so the process of risk assessment seeks to evaluate a 'snapshot' by virtue of the static and dynamic risk factors combined. By focussing on matters that go 'beyond the clinical', risk is more than a clinical measure of the chance of adverse incidents.[50] However, the suggestion that a patient's socio-economic background could become a dominant feature in a Mental Health Act risk assessment was categorically refuted by the interviewees: 'it's not about socioeconomic status, it's about support networks, it's about alternatives to admission'. In spite of this, it was acknowledged that where an individual is living in a deprived area where there are limited support services, the risk of harm to self or others is deemed higher than for someone living in an affluent area with family and friends rallying round. Similarly, some research participants openly recognised that some 'ingredients' such as gender, age, race, and socio-economic background should not influence a risk assessment, but also that these factors inevitably feature in the process. It may be postulated whether the Act inadvertently promotes discriminatory tendencies among the decision-makers who apply it.

Beyond identifying the nature of risk factors used by decision-makers in the study, it is clear that any presumption that within the mental health context there is a reliance on rigid, bright line rules[51] can be rebutted. Gut instinct has a significant role to play and this stems largely from professional experience and the context of decision-making--whether decision-makers are working in an in-patient or community environment. Decision-makers certainly do identify relevant factors, as discussed above, but they then filter these by using 'personal intuition' in order to generate an outcome. The entire research sample acknowledged that you 'can never be 100% sure', and noted that the 'stress in the job' arises from 'a level of unpredictability' attendant on risk assessments. In many respects, decision-makers would argue that part of the skill of a clinician's job is to compare cases with previous experience and to be guided by a kind of self-imposed system of 'binding precedent'. While in theory this approach generates consistency, in practice it has the opposite effect: decision-makers will inevitably attribute different values to certain ingredients in accordance with their own subjective moral codes. This internal system of professional regulation was evident particularly within the assertive outreach professionals in the research sample. Assertive outreach decision-making is strongly underpinned by the benefit of close experience and contact with service users. The Mental Health Act 2007 and the accompanying Code of Practice may provide the skeleton of the decision-making process, but the integrity of the mental health service appears equally dependent on there being a rigorous, disciplined, and ethical self-regulation by decision-makers themselves.

While there was general consensus among the research sample that the 'risk recipe' model reflected the mechanics of determining risk, few participants were able or willing to offer any examples of ingredients or combinations of ingredients that would culminate in a decision to detain a patient under the Mental Health Act. While participants endorsed the model, their evidence suggests that 'anything goes' when a decision-maker tries to establish whether

the 'risk recipe' is complete. Decision-makers draw the ingredients from (i) clinical and/or (ii) social, economic, and environmental factors (non-clinical); while also placing them within a 'static'/'dynamic' configuration. The suggestion that legislators should draft a catalogue of material risk factors from which they must operate was rejected on the basis that such an approach would generate an enormous compendium of factors that would still not cover every relevant issue. It is contended that the production of a comprehensive list of factors would be a hopeless task; as such a list could never completely reflect the myriad of factors which could emerge in any given case. However, the production of a list which does not seek to be all-inclusive, but guiding in character, could be achievable and create a framework, however fluid, which would capture an essence of certainty in an otherwise uncertain landscape.

D. Strategic Decision-making

The absence of a definition of risk, or a clear delineation of the factors relevant to determining it, led to a hypothesis in the research study that the conception of risk facilitates a strategic opportunity for mental health decision-makers. Not only are decision-makers permitted to engage the compulsory powers in the Mental Health Act more readily when the conception's understanding is so mutable but also, by attaching the 'risk' label, a decision-maker can more fully legitimise detention in cases where the evidence may be speculative. Hence, a strategic opportunity is provided to decision-makers to generate desired outcomes while circumventing legal or procedural obstacles. Two models of strategic decision-making flow from this: the 'yardstick' model, and, the 'outcome-based' model.

In the 'yardstick' model, decision-makers use risk as a fact-finding mechanism to determine outcomes. Here, risk is a neutral variable reflecting pre-determined standards. The machinery of this decision-making process involves a patient's diagnosis, characteristics, and circumstances being fed into the framework, which then calculates a risk profile by gauging the extent of the patient's deviation from fixed norms. Decision-making under this model is analogous to using a ruler or 'yardstick' to determine the deviation. This approach underpins standard risk assessment tools, such as where decision-makers 'score' patients in a tick-box exercise. It also underpins the 'risk recipe' model, as discussed above.

In the 'outcome-based' model, decision-makers employ risk as a wholly strategic device to generate desired outcomes. By using the term 'risk', decision-makers could legitimise a patient's compulsory admission to hospital by the (un)intentional concealment of potentially weak or more speculative evidence. In this way, decision-makers can reason backwards by targeting an outcome first then finding the evidence to justify it. The 'value' a decision-maker attributes to risk factors therefore varies depending on the patient and the desired outcome of the process. Such techniques represent a practically expedient solution in a field that handles significant uncertainty. Decisions made in this way allow decision-makers to overcome procedural and evidential gaps to administer necessary treatment and care ultimately for the good of the patient and the wider community.

Peay's work informs the 'outcome-based' model as she found that discussions about the law among mental health practitioners were often 'ill-informed or based on an intuitive understanding, which was not necessarily correct'.[52] Peay discovered that decision-makers employed a 'mix-and-match' approach, picking any factual permutation to justify 'any of ... [a] range of conceivable outcomes'.[53] She also observed decision-makers engage in 'post-hoc rationalisations', whereby they targeted their desired outcome before retrospectively cherry-picking a key factor or combination of factors to justify it.[54] In this way, it was suggested that the law seldom plays a 'determining role' in mental health decisions.[55] During the research study, Peay's assertion was tested with the Mental Health Act 2007 particularly in mind. It was anticipated that risk would have become a more pronounced consideration in the mental health decision-making process because of the policy shift towards the risk agenda.

E. Application of the Models

It was found in the study that the context in which the decision-making process took place and the professional base from which these decisions were generated were again relevant. It was seen that community-based professionals--both psychiatrists and AMHPs--viewed their role as being 'facilitative' and supportive in nature. For that reason, strategic decision-making was less likely to occur in the community than in the acute in-patient context. What was conceded by several community-based research participants was that decision-makers must take a broader view in the process, and that often other steps are commonly taken before using the Mental Health Act. This suggests that the approach found within the 'outcome-based' model may be particularly evident in a non-legal sense, before engagement with the compulsory framework. Interestingly, the data also indicate that there is a slight deviation in response to the 'outcome-based' model from psychiatrists and AMHPs. The psychiatrists, based in the community, were scathing of such an approach, yet several of the AMHPs within the sample acknowledged that they often need to 'change ... [their] mind[s]'. They also agreed that social workers tend to 'err on the side of caution', especially when handling individuals with no history of engagement with mental health services. It was explained that

when managing these 'unknowns', the threshold for compulsory intervention is 'slightly lower'. Indeed, decision-makers may subsequently regret detaining previously unknown patients, but sometimes the team 'cannot afford to take the risk'. It was noted by one participant that: it would be better to 'get it wrong and have somebody in hospital ... for one night than be at an inquest ...'

For decision-makers based in hospitals, the 'outcome-based' model may also not be representative of the decision-making process. For those working at the 'coalface' of acute in-patient care, decision-makers may operate at a lower threshold of risk determination for admission into hospital. Once the mental health services engage a patient, and this is done more easily if the emergency detention[56] or assessment provisions[57] are activated under the legislation, the need for strategic decisions becomes less urgent and the process increasingly resembles the classic 'yardstick' approach.

How the 'outcome-based' model sits with the legislation led to some noteworthy responses by the research sample. Several participants recognised that decision-makers may work backwards to justify a targeted outcome, but said that this sort of approach 'is going to be really difficult to justify ... [under] a section 3 (detention for treatment)'. Many of the acute care psychiatrists in the research sample believed that strategic decision-making occurs legitimately only under section 2 (detention for assessment) of the Mental Health Act. In making this point, the participants seemed unaware that, on a literal construction of its provisions, the Act does not ever permit such strategies.[58] While section 2 permits decision-makers to recommend detention despite gaps in diagnostic knowledge, it still demands a level of risk, albeit at a lower threshold. Other decision-makers adamantly regarded the 'outcome-based' model and the theory of strategic decision-making as not operating on 'the right [legal] premise'; yet, in practice, a patient's risk profile is indissolubly linked to the compulsory admission criteria. Decision-makers must certify that a patient's detention is necessary in the interests of his or her health or safety or for the protection of others. Without this risk to self or others, decision-makers cannot authorise a patient's admission to hospital under the Mental Health Act.

IV. Conclusion

At this early stage of the Mental Health Act 2007's implementation, and its impact as an amendment Act on the application of the Mental Health Act 1983, any conclusions drawn of the impression of the legislation's impact on the clinical landscape must be tentative. The main focus of the research study was risk and how the 2007 Act, as a legislative conduit for governmental policy, was perceived by decision-makers on the ground, at both an individual and an institutional level. Throughout the long and often controversial reform process, governmental policy emphasised the risk agenda; that risk to self or others should be the key trigger of compulsory admission to hospital and that the rights of the wider community to protection from harm should become the predetermining factor in risk assessment. From the empirical data, there is strong evidence to suggest that the risk agenda is now firmly embedded in the legislative framework and whether decision-makers like it or not, they must now deal in the currency of risk.

Risk terminology now has a common usage within the clinical setting, yet defining this notion or giving it some clearer definition remains elusive. Participants of the research recognised that despite reference to and use of 'risk' within their daily activities, they did not have a working definition upon which they relied. Indeed, participants offered circular definitions or restated or paraphrased the statutory criteria for compulsory admission--what has been called in this paper, the 'risk is risk' paradox: decision-makers cannot define risk in the abstract, but they know it when they see it.

When trying to grapple with actual factors, decision-makers used when undertaking a risk assessment, the 'risk recipe' model was developed. Participants were asked what 'ingredients' were sought to determine risk. This model was acknowledged as being a fair representation of the mechanics of risk assessment, as part of the whole decision-making process. However, none of the research samples was prepared to go as far as specifying factors as they all saw such a step has having the potential to fetter their professional discretion. While a patient's clinical history is the most significant risk ingredient, the research team found generally that 'anything goes'. Decision-makers can draw relevant ingredients from (i) clinical and/or (ii) non-clinical factors existing in a patient's diagnosis, characteristics, and/or circumstances.

Clearly, the extensive scope for professional judgement within the legislation presents a strategic opportunity to decision-makers. While, on the one hand, this can be very beneficial to the patient, particularly when considering how positive risk-taking can allow some individuals to remain in the community, despite being chronically unwell. However, it also represents a significant threat to patient rights. The 'outcome-based' model, as part of a strategic decision-making, and drawn from Peay's work, contends that practitioners could use risk as a strategic device to identify an outcome, then work backwards to find the evidence to justify it. This contrasted with the 'classic' understanding of risk as a measure against which practitioners measure patients in order to determine an outcome--the 'yardstick'

model. Apart from one or two participants who saw such a strategic approach as a necessary part of mental health practice, the overwhelming view held that the 'outcome-based' model constitutes the improper use of the Mental Health Act.

It has been contended throughout that an ill-defined, open-ended concept of risk is not conducive to certainty in mental health law. It is argued that the Mental Health Act 2007 exacerbates this problem by introducing a broad definition of mental disorder[59] and the appropriate treatment test without any supporting guidance in terms of how the test should be applied.[60] By broadening the filters for compulsion and decision-makers' discretions in this way, the potential scope for applying the Mental Health Act is significantly widened. None of the interviewees indicated any concerns about this, and instead welcomed the simplified provisions. Also, many were indifferent to the 2007 Act and its implications, taking the view that its provisions simply aligned mental health law with pre-existing practices. Perhaps, most noteworthy is that participants expressed innate trust in their expertise and experience-- their professional judgement, to act as a defence against arbitrary decisions. Whether this should offer comfort to individuals who are subjected to the compulsory provisions of the mental health legislation is questionable as the overwhelming response to the 2007 Act was summed up by one participant:

I don't think it's been the, the big transformation we were expecting, and I think in practice it is still more or less the same, it appears more or less the same to me, apart from the fact that we have these CTOs. It's not what was billed ... It looked like there [was] a certain degree of cop-out occurring in the end and actually when we think that, you know, the previous political administration promised that prior to the '97 election that they would change the law, you know, it took ... many years for not very much really.

The fact that mental health decision-makers do not seem overly aware of or concerned about the changes introduced by the 2007 Act or the opportunities there are for significantly extending the compulsory powers to a much wider group of individuals should raise some disquiet. While the risk agenda remains a fixed concern within the decision-making process (yet risk itself remains a wholly fluid concept), this opens up the prospect for political pressure to steer the decision-making process further towards the public protection agenda. In light of the Mental Health Act's broad criteria and its wide reliance on professional judgment, it is difficult to resist the conclusion that patients' rights will increasingly become secondary to public safety in the post-2007 Act era.

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1 See, e.g., The Lunacy Act 1890, argued by Jones (K Jones, *Asylums and After: A Revised History of the Mental Health Services: From the Early 18th Century to the 1990s* (Athlone Press, London 1993) ch 6) to represent a 'triumph of legalism', provided that no one could be admitted and detained in an asylum without 'certification' under a reception order from the judicial authority (a magistrate or a county court judge). The criteria for detention were that the patient had to be certified as a lunatic, insane person, idiot, or a person of unsound mind and 'a proper person to be taken charge of and detained under care and treatment'. There was no express requirement of dangerousness to self or others, but the petitioner had to state whether the patient was dangerous to others or suicidal. Therefore, though not terminologically explicit, risk to self or others was an important consideration in the decision-making process.

2 See, Department of Health, *Code of Practice Mental Health Act 1983* (The Stationary Office, London 2008) para 4.6, 4.7 (hereafter 'Code of Practice').

3 Decision-makers may rely on 'soft law', such as the Code of Practice, but this is intended to offer broad guidance to decision-makers. While the Code is not legally binding, decision-makers require good reasons to depart from its guidance. Section 118, as amended by the Mental Health Act 2007, confirms this position, as elucidated by the House of Lords in *R v Ashworth Hospital Authority, ex parte Munjaz* [2005] UKHL 58.

4 Mersey Care NHS Trust, *Organisation Portfolio: Clinical Risk Assessment Tools*, March 2009. <http://www.merseycare.nhs.uk/Library/Who_we_are/Policies_and_Procedures/SA10%20-%20Use%20of%20clinical%20risk% 20assessment%20-%20june%2009.pdf>.

5 P Bartlett, 'Civil Confinement' in J McHale and others (eds), *Principles of Mental Health Law* (Oxford University Press, Oxford 2010) para 12.19. See also, J Langan and V Lindow, *Living with Risk: Mental Health Service User Involvement in Risk Assessment and Management* (Policy Press, Bristol 2004) 11 (hereafter Langan and others).

[6] See, M Grann and others, *Psychiatric Risk Assessment Methods: Are Violent Acts Predictable? A Systematic Review(Summary and Conclusions)* 2005. SBU Report No 175 <http://www.sbu.se/upload/Publikationer/Content1/1/Risk_Assessment.pdf> accessed 1 February 2011.

[7] Code of Practice para 1.2.

[8] Mental Health Act 1983, sections 2 (admission for assessment) and 3 (admission for treatment); within both provisions 'threat to health' would be seen as sufficient to enable the appropriate provision to be applied.

[9] As amended by section 1(2) of the Mental Health Act 2007. Mental disorder can be 'any disorder or disability of the mind'.

[10] Even the belief that a mental disorder exists must only be founded on reasonable grounds that an individual is suffering from such a disorder. For example, *R v Kirklees MBC, ex p C* [1993] 2 FLR 187 at 190 and *St George's Healthcare NHS Trust v S* [1998] 3 WLR 936 at 961.

[11] For a detailed and informative discussion of mental health law reforms in the USA, particularly in terms of the focussed public debate on how decisions are made to find the balance between rights and protection, see P Appelbaum, *Almost a Revolution: Mental Health Law and the Limits of Change* (Oxford University Press, New York 1994).

[12] *Bone v Mental Health ReviewTribunal* [1985] 3 All ER 330. See also, Code of Practice, para 4.76.

[13] *R v Mental Health ReviewTribunal for South Thames Region, ex p Smith* [1999] COD 148.

[14] See generally, P Bartlett, 'Civil Confinement' in J McHale and others (eds), *Principles of Mental Health Law*(Oxford University Press, Oxford 2010) (hereafter, Bartlett). See also, *Smirek v Williams* [2000] 1 MHLR 38 (CA) at para 19 in relation to detention for treatment applications under section 3.

[15] N Rose, 'Governing Risky Individuals: The Role of Psychiatry in New Regimes of Control' (1998) 5(2) PPL 177-195, 177.

[16] For example, Mental Health Act 1983 (as amended by the Mental Health Act 2007) sections 20 (duration of authority) and 23 (discharge of patients).

[17] Mental Health Act 1983 (as amended by the Mental Health Act 2007) sections 17A-17G. Where a patient's condition is deemed sufficiently controlled to enable a move to the community, an assessment of that individual's risk will inform the level of care and support provided. For example, for those patients with very unpredictable and challenging conditions, care via an Assertive Outreach Team which offers intensive one-on-one support to an individual in the community might be regarded as the safest option. However, the nature of this service makes it very resource intensive and expensive, so a balancing exercise is required between several, often conflicting, tensions, such as budgetary considerations, availability of services, and the overall risk a patient is thought to pose to others.

[18] P Fennell, *Mental Health: The NewLaw*(Jordans, Bristol 2007) 6.

[19] Department of Health, *Report of the Expert Committee: Reviewof the Mental Health Act 1983* (The Stationary Office, London 1999).

[20] Department of Health, *Reform of the Mental Health Act 1983: Proposals for Consultation*. CM 4480 (The Stationary Office, London 1999), ch 3, para 4.

[21] This study was funded through tender to the Mersey Care NHS Trust Research and Development Funding Scheme 2008-2009. See, N Glover-Thomas, *An Investigation into Initial Institutional and Individual Responses to the Mental Health Act 2007: It's Impact on Perceived Patient Risk Profiles and Responding Decision-Making* (Mersey Care NHS Trust Final Research Report, Liverpool April 2011)

1-170. Research Ethics Approval was obtained from the NHS Liverpool (Adult) Research Ethics Committee (Ref: 09/H1005/54) and Mersey Care NHS Trust Research Governance approval was obtained prior to the commencement of the interviews.

22 The empirical study began with an initial meeting of the study's focus group which comprised key mental health decision-makers with considerable experience and cutting across all levels of mental health care provision from acute in-patient services through to Community Mental Health Teams (CMHTs). This was followed by nineteen semi-structured interviews with psychiatrists, Assertive Outreach Practitioners, Approved Mental Health Act Professionals (AMHPs), hospital managers, and several administrators involved in different aspects of legislative implementation on the ground.

23 Mersey Care NHS Trust, *Organisation Portfolio: Clinical Risk Assessment Tools*, March 2009, p 4.

24 *Sunday Times v the United Kingdom*, Application No. 6538/74, judgment of 26 April 1979, A.30 (1979) 2 EHRR 245, para 49.

25 *HL v UK* (App no 45508/99) [2004] ECHR 471.

26 R Castel, 'From Dangerousness to Risk', in G Burchell and others, *The Foucault Effect: Studies in Governmentality* (Hemel Hempstead, Harvester Wheatsheaf 1991).

27 For a detailed evaluation of risk factors within mental health, developed over a twenty-year research period, see, J Monahan and H Steadman, *Violence and Mental Disorder: Developments in Risk Assessment* (*John D. and Catherine T. MacArthur Foundation Series on Mental Health and Development*) (University of Chicago Press, Chicago 1996).

28 Department of Health, *Best Practice in Managing Risk* (Department of Health, Accepted set by nicola, London 2007).

29 A Perry and others, *Mental Health* (Youth Justice Board, 2008) 1617. <http://www.yjb.gov.uk/Publications/Resources/Downloads/Final%20Mental%20Health%20source.pdf> (last accessed on May 15th 2011).

30 Ibid 17.

31 'Harm reduction' is a phrase that defines policies, programmes, services, and actions that work to reduce the health, social, and economic harms to individuals' communities and society that are associated with the use of drugs and is commonly linked to mental health management.

32 K Kemshall and others, 'Concepts of Risk in Relation to Organizational Structure and Functioning within the Personal Social Services and Probation' (1997) 31(3) Social Policy Administration 213-232 at 213.

33 The difficulty is how to strike a balance between the implicit public protection objectives of the 2007 Act while also recognising that the emergence of risk management processes have seriously eroded and undermined trust between the individual and professional. See M Power, *The Audit Society* (Oxford University Press, Oxford 1997).

34 J Peay, *Decisions and Dilemmas: Working with Mental Health Law* (Hart Publishing, Oxford 2003) (hereafter 'Peay').

35 Peay 20. Indeed, Peay found that only 40% of joint-decision-making between psychiatrists and Approved Social Workers were *ad idem* in recommending compulsion under the Mental Health Act 1983.

36 K Heilbrun, 'Prediction versus Management Models Relevant to Risk Assessment: The Importance of Legal Decision-Making Context' (1997) 21(4) Law Hum Behav 347-359.

[37] Assertive outreach is designed to reduce hospital admissions; reduce length of stay when hospitalisation is required; to increase stability in the lives of service users and their carers/family; and, to improve social functioning in the community environment. Assertive Outreach Teams tend to be made up of a variety of staff from health or social backgrounds, including psychiatrists, nurses, social workers, and occupational therapists. These teams have a lower case load than traditional CMHTs; they see their clients more frequently and stay in contact, even when there are engagement problems. Such care is often provided in the patient's own environment. For more detail on this mode of psychiatric care and support, see, T Burns and M Firn, *Assertive Outreach in Mental Health: A Manual for Practitioners* (Oxford University Press, New York 2002).

[38] Positive risk taking occurs when a decision is made to weigh up the potential benefits and harms of exercising one choice of action over another, with particular emphasis on the positive potentials and stated priorities of the service user. 'It involves using available resources and support to achieve the desired outcomes, and to minimise the potential harmful outcomes. It is not negligent ignorance of the potential risks ... it is usually a very carefully thought out strategy for managing a specific situation or set of circumstances', see S Morgan, 'Positive Risk-taking: An Idea Whose Time Has Come' (2004) 10(10) Health Care Risk Report 18-19. See also D Carson, 'Developing Models of Health to Aid Cooperation between Law and Psychiatry' (1996) 6(1) Crim Behav Mental Health 6-10.

[39] For example, one research participant referred to risk in terms of significance, implying that decision-makers do indeed interpret it as a 'divisible' concept.

[40] G Szmukler and F Holloway, 'Reform of the Mental Health Act: Health of Safety?' (2000) 177 Br J Psychiatry 196-200.

[41] Community Treatment Orders (CTOs) may offer the solution to this very real concern. A patient who has been subject to a 'treatment' section in hospital may be eligible for a CTO. However, it is quite possible that the CTO regime in England and Wales, which has a 'least restrictive' rather than 'preventive' character, will offer little scope to deal with patients who sit squarely between the acute in-patient service and the community mental health service and are often dealt with by Assertive Outreach Teams. For a detailed discussion of the merits and difficulties surrounding CTOs, see R Churchill and others, *International Experiences of Using Community Treatment Orders* (Department of Health, London March 2007),<http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_072728.pdf> accessed 28 February 2011.

[42] For a wider discussion on how risk is used to define and regulate activity in several areas, see C Hood, H Rothstein and R Baldwin, *The Government of Risk Understanding Risk Regulation Regimes* (Oxford University Press, Oxford 2001).

[43] H Mintzburg, 'Structure in 5's: A Synthesis of the Research on Organization Design (1980) 26(3) Management Sci 322-341.

[44] J March, H Simon and H Guetzkow, *Organizations* (2nd edn Blackwell Business, Oxford 1993)160.

[45] T Honoré, *Responsibility and Fault* (Hart Publishing, Oxford 1999) at 2 (hereafter, 'Honoré').

[46] Honoré 120.

[47] For a broad discussion of these factors and their nature, E Elbogen and others, 'Perceived Relevance of Factors for Violence Risk Assessment: A Survey of Clinicians' (2002) 1(1) Intl J Forensic Mental Health 37-47.

[48] Predominately, tick-box style decision-making is used for blame avoidance purposes, see C Hood, *The Blame Game: Spin, Bureaucracy, and Self- Preservation in Government* (Princeton University Press, Oxford 2010) 11, 93-97.

[49] Bartlett, Accepted set by nicola, para 12.20.

[50] See M Grann, K Sturidsson and U Haggård-Grann, 'Methodological Development: Structured Outcome Assessment and Community Risk Monitoring (SORM)' (2005) 28(4) Intl J Law Psychiatry 442-456.

[51] CR Sunstein, *Legal Reasoning and Political Conflict* (Oxford University Press, Oxford 1996).

[52] Peay 29.

[53] Peay 40.

[54] Peay 74.

[55] Peay 67.

[56] Mental Health Act 1983, section 4 (emergency admission).

[57] Mental Health Act 1983, section 2 (admission for assessment).

[58] The Mental Health Act Code of Practice notes that under section 2, the full extent of the nature and degree of a patient's condition may often be unclear.

This is unsurprising as section 2 allows a patient to be admitted to hospital for psychiatric assessment. Yet, to justify such admission there must still be evidence of *some* 'nature or degree' of mental illness to justify detention, but inevitably the full extent of that nature or degree is not known at the time of admission. As such, there may be a need to carry out an initial in-patient assessment in order to formulate a treatment plan, or to decide whether the patient will accept treatment on a voluntary basis following admission, see Code of Practice, para 4.26.

[59] Code of Practice, para 3.3.

[60] However, chapter 6, Code of Practice, indicates that the threshold for risk should be set at a fairly low level; however, no detailed guidance is provided which demonstrates just how this should apply in practice.