

Reading 16 Mental health, mental disorder, risk and public protection

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Introduction

Mental health provision is one arena in which needs, rights and risks have long competed. In the Middle Ages the mentally ill were risk managed through expulsion or incarceration and exclusion through the ‘ship of fools’ (Foucault 1965). The Enlightenment provided an early example of privatized mental health care through profit-oriented ‘madhouses’. The Victorian period and the early twentieth century were dominated by the spectre of the asylum and the concept of containment (Foucault 1965), although the walls between asylum and local communities were often permeable (Bartlett and Wright 1999) and ‘lunatics’ could be just as much ‘at risk’ in the community as in the asylum (Melling 1999). The deinstitutionalization of the post-Second World War period was based upon a consensus that large institutions were dehumanizing and prone to abusive relationships with patients. The anti-psychiatry movement in particular recast the asylum itself as a place of risk, and most mental health patients were seen as presenting a low or tolerable risk to the community if released. The latter part of the twentieth century saw the development of community care for the mentally ill. Carpenter (2000) has presented this deinstitutionalization as in part a response to the fiscal crisis of post-1945 welfare provision and advances in neo-liberal techniques of social control – in particular, the dispersal of the asylums’ power and social control functions to the individual in the community through the ‘psy’ disciplines of psychiatry and psychology. The state’s overt control is displaced to the control of experts and professionals, and the self-regulation of the individual through adaptation to the preset norms of the normalizing disciplines (Rose 1985, 1986). As Carpenter (2000: 605) expresses it, the widening of social control is achieved through ‘a co-optive rather than a repressive process’. Fiscally, community care (or community neglect, as Scull has dubbed it), has become a cheap alternative for the management of ‘labour market casualties’ in post-Keynesian markets (Scull 1979, 1993). Pilgrim and Rogers (1999) have identified four key elements in the development of community care provision:

- fiscal crisis in post-1945 welfare provision, resulting in deinstitutionalization;
- the rise and dominance of drug and physical treatments;
- the influence of cost-effective considerations and concerns with evidence-based treatments;
- the rise and influence of user groups and civil liberty considerations in mental health policy and provision.

This has been paralleled by mental health legislation such as the 1983 Mental Health Act, which reduced the medical orientation of mental health services to incorporate increased emphasis upon individual rights, support services and social needs (Fennell 1999). Ryan (1996) has expressed the history of mental health risk management in six stages, with distinct risk management strategies and sites of management (see Table 16.1).

Table 16.1 The history of risk management

Period	Risk management strategy	Risk management site
Middle Ages	Expulsion	Banishment and ships of fools
Enlightenment	Confinement	Private jails and madhouses
Victorian era	Incarceration	Asylums
Early twentieth century	Treatment	Psychiatric hospitals
Mid-twentieth century	Decarceration	Community
Late twentieth century	Integration	Community

(Source: Ryan (1996: 101). Reproduced with the kind permission of Jessica Kingsley Publishers.)

The Community Care Act 1990 was followed by a policy emphasis upon partnership and coordination of services epitomized by the ‘Care Programme Approach’ (CPA: Department of Health 1990a), and practice guidance for care management (Department of Health 1991). Care management and its predecessor, case management, were seen as essential techniques for adequately meeting client need and coordinating disparate resources into ‘care packages’ (Ryan *et al.* 1999). Case management was short-lived and focused upon the assessment and delivery of care in the community by health care professionals within a needs-led model (Onyett 1992). Care management, with its emphasis upon developing and managing care packages, superseded the needs-led approach with service-led control of provision under the umbrella of the CPA. The 1990s saw the tensions between risks, needs and rights in mental health provision sharpen. Risk became central to decisions made by approved social workers to detain mentally ill persons compulsorily under the Mental Health Act 1983. Risk reduction also became central to assessment and provision under the CPA (Davis 1996). However, as Davis (1996: 109–10) puts it,

Risk is ... emerging as a key but contested concern in the mental health field. It is being discussed in a climate in which political, professional, organisational and service users’ interests and territories are being actively re-negotiated. It is thus important in considering risk work to take continuous account of the political, professional and resource interests that are influencing its development and direction.

Davis identifies two such developments: risk reduction and risk taking.

Risk reduction

The risk reduction approach has been fuelled by a series of high-profile mental health enquiries, such as Georgina Robinson (Blom-Cooper *et al.* 1995) and Christopher Clunis (Ritchie *et al.* 1994), which exposed flaws in the community care system to meet the care needs of the individuals concerned and to protect the public from risk. The CPA was introduced in 1991 to coordinate both assessment and interventions across a wide range of agencies and professionals, and risk, to both self and others, is seen as integral (Department of Health 1994a). This was supported by the Blom-Cooper inquiry, which stressed the ‘ongoing assessment of risk and risk-management, assuming that risk will change over time and can be managed effectively’ (Blom-Cooper *et al.* 1995: 176). CPA also used risk to prioritize cases, using a tiered approach

comprising ‘minimal’, ‘low support needs which are likely to remain stable’ and ‘complex’ assessments for those whose needs are ‘less likely to remain stable’ (Davis 1996). Resource-intensive multidisciplinary assessments are reserved for those individuals ‘suffering from severe social dysfunction, whose needs are likely to be highly volatile, or who represent a significant risk’ (Department of Health 1994b). This has focused attention (and services) upon a small residual group of ‘high-risk’ individuals who are deemed to present a danger to the public. Provision has been skewed towards the identification, assessment, registration and surveillance of this group, and as ‘a consequence it fails to engage adequately with the issues of risk as they affect the majority of service users’ (Davis 1996: 113).

Risk taking

Risk taking has its roots in user empowerment, service user involvement and anti-oppressive mental health practice, and is seen as a necessary part of life and a right of mental health users (Braye and Preston-Shoot 1995). Normalization rather than risk reduction is a key feature of this approach, and risk is seen as integral to autonomy, quality of life and citizenship (Ramon 1991, Brown and Smith 1992). This approach is underpinned by radical values of empowerment and structural change:

On the one hand are values located in a long tradition of social care. These urge practitioners to ‘treat people better’ in the context of allotted roles and place in the social structure. On the other hand are values calling for radical change to, and renegotiation of, existing roles and social structures, to create a fairer society. Thus the traditional agenda is to bring about the adjustment of service users to existing conditions in society, a focus on personal problems. The radical agenda emphasises the structural context in which problems are produced and reproduced.

(Braye and Preston-Shoot 1995: 35–6)

Risk taking is often advocated by user groups, and is used to challenge the oppressive or restraining practices of professionals. It can thereby form an important limit to risk reduction as the bases of decisions to limit rights or choices have to be explicit and competing risks and rights have to be balanced (MIND 1986; Carson 1988, 1990, 1994, 1996). It has also been seen as essential to the reduction of stigma, dependency and over-protectiveness, a common feature in the lives of the mentally ill (Barham and Hayward 1991). However, while community care and risk taking have emphasized client needs and rights, in reality mental health risks have been increasingly negatively defined and community care has become focused on how to increase compliance with community treatments and surveillance (Ryan 1996). Mental health is now dominated by concerns with low-frequency/high-impact risks of homicide and suicide, with the high-frequency/low-impact risks faced by users in their daily lives largely neglected (Ryan 2000).

Summary

Deinstitutionalization and the shift to community care have sharpened attention to risk, particularly in assessment and resource provision. However, risk is a ‘contested’ area in which risk reduction and risk taking can be at odds, and the user’s right to take risks is dominated by professional views of risk reduction. Community care has become preoccupied with risk avoidance and risk management, resulting in a largely negative view of user risks and a deprioritizing of user rights.

Mental health risks in the risk society

Frank Furedi (1997: 4) has argued that the ‘evaluation of everything from the perspective of safety is a defining characteristic of contemporary society’. This ‘worship of safety’ is a key characteristic of life in the risk society, focusing attention on ‘hazards’ and ‘threat’ and prudent responses to them. As Furedi (1997: 4–5) puts it, ‘By turning risk into an autonomous, omnipresent force in this way, we transform every human experience into a safety situation.’ Human activity is characterized by risk aversion, and risk regulation is characterized by the ‘precautionary principle’. Paradoxically this can lead us to over-perceive risks and to be fearful even in conditions of comparative safety. Media inflation of risks (Kitzinger 1999) and a lack of ‘lay’ trust in expert systems to regulate risks have exacerbated this. Mental health risks are no exception. The Mental Health Advisory Committee to the National Association for the Care and Resettlement of Offenders (NACRO) noted that while community care had ‘placed the public at a slightly greater risk’ this was not because the risks presented by mentally ill people were unacceptably high, but was due to failures in the system and the resource-led rather than needs-led nature of provision (NACRO 1998: 48). Mental health risk management failures have also heightened public and policy-makers’ views that professional work with this group requires increased regulation and accountability (Sheppard 1996). Professional decision-making also takes place in a climate of blame, and exhortations to ‘defensible decisions’ abound (Carson 1996). Blame serves to strengthen accountability, but also subtly to control information flow and usage, and to reinforce loyalty and solidarity with particular viewpoints on risk: ‘News that is going to be accepted as true information has to be wearing a badge of loyalty to the particular political regime which the person supports; the rest is suspect, deliberately censored or unconsciously ignored’ (Douglas 1992: 19). In mental health practice this can result in the legitimization of professional views on risk at the expense of user or carer views. Competing views of risk result, not least between ‘lay’ public and experts. The subjectivity of risk assessment is now largely accepted (Royal Society Study Group 1992), but the responsibility of professionals to make the ‘right decision’ is emphasized by the power of hindsight bias. While the position on practitioner liability is less clear in the UK, cases such as *W v. Edgell* have clearly indicated that professionals should err on the side of public protection (Prins 1999). Professionals are also charged with deciding acceptable risk, a difficult task in an era of competing perspectives and values on risk.

Mental health has also long been a site of contested concepts, diagnoses, taxonomies and interventions, as evidenced by contemporary histories of insanity and psychiatry (Shorter 1997; Melling and Forsythe 1999) and historical sociological analyses of madness and its management (Scull 1979). As Table 16.1 indicates, definitions of, and responses to, mental disorder are also products of their time. Based upon detailed historical research, Scull has argued that the development of the Victorian asylum owes much to the weakening of community ties and traditional management techniques of mental disorder by the modernization of economic life and labour relations. The ‘social casualties’ of the emerging modern market environment were dealt with through institutionalization, and the purpose of such asylums was to

model social behaviour around the norms of rational bourgeois expectations. Damaged human capital was repaired and worthless labour was warehoused in the corridors and buildings which quickly became museums filled with lifeless artefacts of humanity.

(Melling 1999: 3)

The ‘history of madness’ has been characterized as a complex interaction between labour regulation, penal regulation and the development of medical practices to discipline the population (Foucault 1965), key intersections in the modernization process (Melling 1999).¹ While such historical constructions are themselves often contested, what is clear is that mental health has a long association with the process of modernization and the problem of order. As Harris (1999: 10) puts it, ‘Looking at how we comprehend the seemingly irrational few tells us how we comprehend, without even thinking about them, the taken-for-granted seemingly rational many.’ Mental disorder is therefore always defined with reference to an often unspoken and implicit norm. Defining mental health, especially as ‘risky’, is also central to the identification and solidarity of the included, as well as the exclusion of the ‘other’ (Douglas 1992). While the asylums have closed, the mentally ill are still with us and have become a site of control and public protection (Bartlett 1997).

Mental health and social order

Bartlett has argued that the legacy of the asylum runs deep, and is still the defining metaphor of mental health care today.

As Porter (1987: 35) has expressed it, we have ‘a deep disposition to see madness as essentially Other’. This is not merely a matter of management or the administration of key services, it defines ‘the terms on which people with mental illness are to be accepted in social life’ (Bartlett 1997: xiii). The role of mental health provision and its attendant discipline psychiatry in defining the excluded and alienated other against a rational norm has been well argued:

Society has progressively defined itself as rational and normal, and by doing so has sanctioned the stigmatizing and exclusion of ‘outsiders’ and ‘aliens’. And the particular device of the walled and locked asylum – which after all ended up housing far larger populations than did prisons – backed by the medical speciality of institutional psychiatry ... underscored the differentness, the uniqueness, of those thus ‘alienated’ and ‘excluded’.

(Porter 1987: 25)

Thus processes of deinstitutionalization can themselves stigmatize and dehumanize, and mentally ill persons in the community can find themselves both alienated and socially isolated.

From mental patient to mental health case

The deinstitutionalization movement gathered pace by the 1960s, and institutional psychiatry was increasingly replaced by the notion of the ‘therapeutic community’, in which hospitals would provide brief respite and short-term treatment before reintegrating the patient into the community. Significantly, this reintegration was not based upon any acceptance of difference or counteraction of exclusion, but was aimed at abolishing difference through treatments that would normalize (Bartlett 1997). Patients would accommodate to their environments through the use of drug treatment and medication. For Bartlett, this rendered the community or environment a neutral venue, not a site of dispute, conflict, risk or threat to patients, merely a place to which they could be returned. Social sites would not require management, but individual patients would, and drug regimes, particularly administered through outpatients clinics, fitted the bill. While psychiatry managed to throw off its

¹ It is beyond the scope of this chapter to present a full overview of the ‘history of madness’. For further illumination, and at times competing views, see Foucault (1965), Scull (1979) and Melling and Forsythe (1999).

institutional custodial function, this function was subtly relocated to the community. The long-term and often immutable label 'mental patient' was replaced with the more provisional label 'mentally ill person' (Bartlett 1997), and in the case management language of the Community Care Programme the person became a 'mental health case'.

Community care provision for the mentally ill has been subject to the same limits of resource constraint and selectivism as other areas of the personal social services. Paradoxically, this has resulted in the invisibility of the majority of mentally ill persons and increased attention to the identification and regulation of a few high-risk cases. This trend is compounded by the tiered priorities for intervention and provision under the CPA, in which instability, significant risk and severe social dysfunction are essential criteria for intensive services. The Mental Health Foundation, in a report on community care provision for severe mental illness, has estimated that there are some 300,000 people with severe mental illness in England and Wales, but the report acknowledges that defining the term 'severe mental illness' is problematic, and conditions change (Mental Health Foundation 1994). This difficulty is exacerbated by mental health legislation that has traditionally defined mental illness and provided various taxonomies of illness to assist with compulsory admissions and detentions. Such legal definitions of mental illness have a limited role in classifying mental illness when its management is displaced to the community.

The invisibility of mentally ill persons not only prevents appropriate access to services, it also compounds their vulnerability. The vulnerabilities and risks of the asylum are merely displaced to the community, with ex-patients suffering abuse, poverty and social isolation (Bartlett 1997). The inadequacy of community care services to respond to this group was highlighted in various reports, with the National Schizophrenia Fellowship (1989) using the metaphor of 'Slipping through the net' to describe the problem. Such 'nets of care' come under scrutiny when they are deemed to have failed, and the invisibility of the majority is brought into sharp contrast with the minority who become the subject of inquiries. While the 1975 White Paper *Better Services for the Mentally Ill* (DHSS 1975) had accepted that the majority of mentally ill people were not especially dangerous and could therefore be appropriately managed in the community, the inquiries of the 1990s in particular focused attention on the few for whom, with hindsight, community care was deemed inappropriate. The Butler Committee in 1975 had attempted to define and introduce a two-tier system of mental health care, with the high-risk minority being selected out for secure hospital accommodation (Home Office and DHSS 1975). This, and the Glancy report (DHSS 1974), established the system of special hospitals and regional secure units for the 'dangerously' mentally ill. However, as the more recent NACRO review makes clear, the underlying assumption that it would be possible to identify and separate high- from low-risk patients was misplaced, and reliable risk assessment tools have been illusive (NACRO 1998; Prins 1999).

Mental health inquiries and the failure of community care

A major impetus in the move to community care was to ensure greater and more relevant provision for the mentally ill from health and social services, epitomized by the document *Better Services for the Mentally Ill*. Central to government policy on mental health was the introduction of the CPA in 1990 (Department of Health 1990a, b). The CPA emphasized assessment, a care plan, an allocated key worker for each case and regular review of progress. The

CPA represented an acknowledgement that the principles of community care following hospital closures required tighter structures and systems for their delivery. However, resources remained a key issue in the adequate delivery of the CPA (Davis 1996; Ryan 1996). Disquiet about the adequate management of mentally ill persons in the community was fuelled by what Grounds (1996) refers to as a new generation of inquiry reports from the late 1980s onwards, in which the focus of attention was homicides perpetrated by mentally ill persons. These reports attracted greater media attention and public disquiet than their predecessors, which had focused on the abuse of patients in psychiatric institutions. The most notable of these were Christopher Clunis (Ritchie *et al.* 1994), Andrew Robinson (Blom-Cooper 1996) and the two overviews of inquiries prepared by Sheppard (1997, 1998). The inquiries highlighted specific procedural and systems failures in the care of dangerous and violent mentally ill persons in the community.

The reports highlighted the following:

- inadequate coordination and poor communication between professionals and agencies;
- lack of appropriate resources, including secure beds as well as community provision;
- the need for special supervision arrangements;
- inadequate information sharing and recording;
- inadequate and unreliable assessment of risk and violent behaviour;
- lack of cooperation between agencies;
- patients' rights required greater attention, in particular the right to have their needs met, and to express their needs, wishes and choices;
- legislation required attention, in particular for supervision on discharge from hospital and for compulsory treatment and supervision in the community (adapted from NACRO 1998: 24; Sheppard 1997, 1998).

The cumulative impact of the inquiry recommendations and their attendant publicity subtly moved the mental health agenda from care to management, and from treatment and rehabilitation to control and surveillance. Risk and protection began to dominate the mental health policy agenda (Grounds 1996). This is evidenced by:

- specific policy development and practice guidance on mental health management of high-risk cases in the community and the development of compulsory community care;
- the increased attention to mentally disordered offenders;
- the development of preventative detention for high-risk cases.

Summary

Risk avoidance and the 'worship of safety' are key features of mental health policy. The 'history of madness' has been characterized as a history of social regulation and normalization of the 'Other', in which segregation, surveillance and control of the mentally ill are central. The metaphoric segregation of the asylum is still pervasive in the constitution of community care, with social control functions transferred from asylum to community. Deinstitutionalization is not characterized by reintegration, but by the invisibility of 'low-risk cases' on the one hand and extensive management of more risky individuals on the other, resulting in a two-tier system of mental health provision.

Individualization through individual targeting shifts attention from structural issues and social site management to regulating the behaviours of individuals and compensating for any lack of prudentialism or risk management.

Responsibility for risk is firmly individual, either of the worker or patient-worker for failing to manage it effectively, or of patients for failing to comply with risk management strategies. The failure of such strategies inevitably attracts public and media attention, and community care has been subject to regular and notorious public inquiries on its shortcomings.

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