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Chapter 36

'Digitising The Mental Health Act'

Are we facing the app-ification and platformisation of coercion in mental health services?

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'DIGITISING THE MENTAL HEALTH ACT'

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Introduction

In 2019, an industry publication called the *Medical Futurist* (2019) imagined a near future:

[P]atients might go to the hospital with a broken arm and leave the facility with a cast and a note with a compulsory psychiatry session due to flagged suicide risk. That's what some scientists aim for with their A.I. system developed to catch depressive behavior early on and help reduce the emergence of severe mental illnesses.

This is one imagined future for mental health services. Others have rejected a forecast of expanded risk predictions and coercive intervention (see e.g. McQuillan, 2018), instead promoting co-operative support relationships augmented by selective use of data-driven technology (see e.g. Bossewitch, 2016; Cosgrove et al., 2020).

These contested futures are beginning to appear in the mainstream – often in the pages not of mental health journals but of financial news. Consider Elon Musk's claim that his 'AI-brain-chips company could "solve" autism and schizophrenia' (Hamilton, 2019) or the *MIT Technology Review* description of a mobile app 'that can tell you're depressed before you know it yourself' (Metz, 2018). The latter app, called *Mindstrong*, was developed with funding from Jeff Bezos' capital firm (Murtha, 2018), and its inaugural director and co-founder, Thomas Insel, joined the company after leaving a role at Google, where he had pursued a 'Big Data' approach to mental health (Reardon, 2017). Insel had previously been the director of the US National Institute of Mental Health (NIMH). Between 2009 and 2015, NIMH (2017) disbursed US\$445 million to projects concerned with 'technology-enhanced mental health interventions'.

Despite the attention-grabbing claims of the *Medical Futurist*, and indeed of Musk, many such proposals are the stuff of speculative fiction. Often, there is scant evidence for the technical feasibility of their claims, except in the most exploratory of terms. Even claims about the *Mindstrong* app are promissory, and like many algorithmic and data-driven proposals in men-

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tal healthcare, they lack a robust evidence base; its website supports the product with reference to a single study with a total sample of 27 people (Corbyn, 2021; Dagum, 2018). This point is important because even critical responses to new technologies, such as an analysis of their legal and ethical downsides, risks amplifying the sensational claims behind them. This inadvertent hype can exaggerate the technical feasibility of a proposal and risks promoting a 'distorted picture of science's potential' (Horgan, 2021). An even greater risk, according to historian of computational technology David Brock (2019), is that 'wishful worries' about speculative futures can distract us from the 'actual agonies' of technology-use today.

Indeed, for the purposes of this chapter, there are several forms of digital data-driven technologies that are being used today, which are starting to reshape processes of mental health-related law in some countries. These technologies may not be as sensational as 'AI brain-chips' or forms of algorithmic pre-vision, but these more mundane technical systems – in particular, video-conference software, online platforms for managing healthcare labour, and electronic health records – have significant legal ramifications for people facing involuntary psychiatric intervention. This chapter will turn to these sociotechnical systems¹ as a way to reflect on the digital futures of mental health-related law.

Specifically, the chapter will focus on the explicit policy aim to 'digitise mental health legislation' in England and Wales, with reference to the *Mental Health Act 1983* (England and Wales) (MHA). I will look at three developments: (1) the rise of digital platforms to coordinate MHA assessments of those facing involuntary intervention, (2) the use of vide-ocall technology to make remote medical assessments to authorise intervention under the Act, and (3) remote video hearings of mental health tribunals. Some of these developments are not unique to England and Wales, and brief comparative points will be made with other jurisdictions. Yet, the chapter will focus on English and Welsh law and policy given 'digitising mental health legislation' (HM Government, 2018, p. 213) is an explicit policy aim, unlike elsewhere.

Beyond a descriptive account of the evolving law, policy, and practice, the final section will reflect on these experiments and look to the levers in policy and law that can help govern them responsibly. I will consider human rights concerns raised by 'digitising' mental health legislation, and draw in a political economy perspective to reflect on the role of the private sector in emerging configurations of digitised health and social services. I will argue that although courts appear responsive to the impact of videocall platforms on the direct application of the MHA – specifically for remote medical assessments and tribunal hearings – there appear to be less obvious means to monitor and respond to the use of digital platforms in administering MHA-related crisis work, and in the broader 'platformisation' of health and social services (Faulkner-Gurstein and Wyatt, 2021). Even as there remain open questions about the role of videocall technologies in hearings and assessments (for example, concerning access to justice for those subject to MHA orders or the experimental use of remote

^{1 &#}x27;Sociotechnical systems' refers to a 'system involving the interaction of hard systems and human beings, in ways that either cannot be separated or are thought to be inappropriate to separate' ('Socio-Technical System', n.d.). It offers a concept for analysing the dynamic interaction of people and technology, rather than narrowly focusing on merely the technology itself. The concept has origins as an extension Sociotechnical Theory, which emerged from organisational development in organising complex work, and which offers language for describing, analysing, and designing organisations, and has become a widely used concept for studies in human computer interaction (Baxter and Sommerville, 2011). For the purposes of this paper it is used to refer to the digital systems under discussion, and the people and social structures that interact with them.

medical assessments for people under community treatment orders (CTOs) in Scotland), more pressing questions arise regarding the checks and balances in place for the use of private digital platforms for facilitating the setup by mental health practitioners of compulsory treatment and hospital detention.

Background: 'Digitising the Mental Health Act' in England and Wales

Today, electronic records and official forms are more easily transferable across communication systems than ever before. The growing interconnectedness and complexity of these systems has driven efforts by governments – and, increasingly, private market actors – to digitise processes of involuntary psychiatric intervention. The COVID-19 pandemic has accelerated these developments. Social distancing prerogatives have helped strengthen information communication infrastructure and remote technologies in many health and social care systems. The pandemic has also arguably created a 'seller's market' for private technology vendors seeking to disrupt traditional forms of service delivery (see e.g. Teräs et al., 2020).

In 2018, the British government recommended 'digitising ... the Mental Health Act' (HM Government, 2018, p. 213) following its major review of the MHA for the Department and National Health Service (NHS) England and Improvement. The recommendation aimed to provide 'patients with a modern and consistent way to access information about the Act, their rights, safeguards and treatment processes' (HM Government, 2018, p. 213). Digitising administrative requirements, it was suggested, could help reduce delays (including during the assessment process), maximise the time professionals could spend with their patients, and 'improve patient access to care records, care plans, treatment preferences and advance choice documents, and the details and wishes of nominated persons' (HM Government, 2018, p. 213). Clinical decision tools could be integrated, including those that prompt clinicians to carry out 'observations or assessments before tribunal deadlines', and patients could 'benefit from digital access to information, self-care tools and easily navigable forms of clinical and non-clinical support' (HM Government, 2018, p. 213). These aims sat within the broader recommendation 'to test, evaluate and roll-out a fully digitised, consistent approach to the MHA' (HM Government, 2018, p. 213).

Digital platforms for professionals conducting MHA assessment setup and claim form processes

Within this context, private sector actors and government agencies have created various online platforms designed to assist the mental health professionals who are seeking to apply the MHA and impose involuntary psychiatric intervention over a person (see s12 Solutions, 2022; Thalamos, 2022a; Stevens et al. 2022). For example, one for-profit company, *s12 Solutions* (2022), established an online platform that allows social workers, nurses, psychologists, and others who are interacting with a person in crisis to locate and communicate with authorised medical practitioners (s12 Solutions, 2022). Such practitioners may assess the person and authorise involuntary intervention, as well as completing and submitting payment claim forms for their work. At the time of writing, the company reports that its product is used by approximately 75% of England's Mental Health Trusts (S12 Solutions, 2022).

s12 Solutions is so named because Section 12 of the MHA establishes provisions regarding medical recommendations for involuntary intervention. Subsection 2 requires one of the medical practitioners making a recommendation for the involuntary admission of patients to hospital to be authorised by the Secretary of State as having 'special experience in the

diagnosis or treatment of mental disorder' (*Mental Health Act 1983* (England and Wales) [12(2)]). The role of a digitised triaging platform like *s12 Solutions*, according to Stevens and colleagues (2020, p. 16), is to enable 'authorised mental health practitioners' or AMHPs² to 'contact section 12 doctors, to arrange MHA assessments'. Further, within the platform:

approval of involved doctors is checked against the national database on a weekly basis ... Section 12 doctors can enter their availability on a personal calendar and 'build a profile containing their location, specialities and languages spoken, and monitor their activity via a dashboard'. Doctors can also use the platform to record the assessments they have attended, to provide supporting evidence for Continuing Professional Development. In addition, the app provides data capture and reporting about the MHA assessment process.

(Stevens et al. 2020, p. 16)

The platform was endorsed by a Chief Executive of one NHS Trust (s12 Solutions, 2020), who, according to *s12 Solutions*, described the company as '[t]he Uber of finding doctors for the health service' (S12 Solutions, 'What is S12 Solutions?' Twitter (21 Jan 2020) https://twitter.com/S12Solutions/status/1219262300667961349 [accessed 19/05/2021]).

Loosening regulation of the electronic communication of statutory forms under the MHA

Two years after the 2018 recommendation to digitise the MHA, and following the outbreak of COVID-19, mental health treatment regulations were amended in December 2020 to allow electronic communication of statutory forms under the MHA (*The Mental Health (Hospital, Guardianship and Treatment) (England) (Amendment) Regulations 2020*). Another for-profit company, which provides a platform for streamlining professionals' administrative activities under the MHA, *Thalamos* (2022b), noted the legislative amendment on its website, stating that 'we have even helped change the law'. The amendment advanced the 2018 Review of the MHA in its aim to speed up applications for compulsory intervention orders, while also aiding with pandemic-related imperatives to socially distance. The changes were made, according to the Department of Health and Social Care (England and Wales) (2020, s 7.5):

because developments in information technology allow for integrated and secure information systems in the NHS, which serve patients by keeping relevant clinical information about them so that services can respond to the needs of patients quickly and appropriately. Such systems have the potential in this case to help professionals follow the requirements of the Act in ways that do not use their time unnecessarily, for example by waiting to receive signed paper forms.

² Approved Mental Health Professionals were introduced by the *Mental Health Act 2007*, which amended the *Mental Health Act 1983*. Their role is primarily to coordinate the assessment of individuals who are being considered for detention under the *Mental Health Act 1983*. They are typically social workers but may be nurses, occupational therapists, and psychologists, with varying accreditation requirements.

Research concerning the online triaging and form-processing platforms sheds some light on the changes created by these amendments, and appears largely positive.

A 2022 study on the availability of 'Section 12 approved doctors' in England and Wales, for example, specifically asked a range of approved doctors, AMHPs, NHS managers, 'Chair of Approvals Panels', and other key informants (n=52), about using the *s12 Solutions* app (Stevens et al., 2022). The interviewees reported three main advantages of the app:

- 1. it provides information about the availability of section 12 doctors and their sub-specialisms;
- 2. facilitates the payment of fees to section 12 doctors;
- 3. and supports the 'smooth running' of MHA assessments, which reduces AMHPs' workloads (Stevens et al., 2022, p. 60).

These noted benefits are consistent with an earlier evaluation by the Wessex Academic Health Science Network (2020). This Network is an NHS-managed public-private entity self-described as a partnership of 'NHS and academic organisations, local authorities, the third sector and industry' (The AHSN Network, 2022). I will return to the Academic Health Science Network later in the chapter.

A small number of interviewees in Stevens and colleagues' (2022b, 3) study expressed concerns about the *s12 Solutions* app. These concerns include that:

- dependence on the internet could limit its application in some areas;
- the app could potentially mean that AMHPs would be less likely to seek the involvement of a section 12 doctor who knows the patient, because of easy access to large numbers of section 12 doctors;
- reluctance by some AMHPs or section 12 doctors to use the technology;
- some AMHPs may wish to use their lists of known and trusted section 12 doctors; and
- a small number of technical problems had been experienced.

(Stevens et al., 2022b, iii)

Several interviewees also expressed a preference for the app to be developed and owned by the Department of Health and Social Care and raised concerns about how much it costs and whether public services should pay for it (Stevens et al., 2022b, 3). Perhaps for this reason, one Clinical Commissioning Group (an NHS organisation set up to organise the delivery of NHS services in England) created its own app, though little information about the app is publicly available (Stevens et al., 2022b, iii).

Elsewhere, some mental health services users have raised concerns about the unknown impact of the digitised triage process on those who use services or are subjected to involuntary interventions (Mental Elf, 2020). The potential for AMHPs to seek a section 12 doctor out of convenience rather than a doctor with whom the person is familiar would be a significant issue in this regard. However, this concern would seemingly extend beyond the *s12 Solutions* app to the NHS-run national MHA Approvals Register Database, which provides a list of 9000+ section 12 doctors. Nevertheless, no research appears to have explored this concern in much depth nor sought the views of service users or those whose MHA detention was facilitated by digital platforms.

One major legal concern to arise following platform-use for mental health crisis work is the use of videocalls by section 12 authorised doctors to conduct remote personal assessments of those facing MHA interventions.

Videocall assessments for authorising detention: England

Administering involuntary psychiatric interventions via online platforms affords the possibility of remote expert assessments of an individual to determine if an intervention should occur. Remote MHA assessments were encouraged by the NHS in the early stages of the pandemic but in 2021 they were ruled by the High Court of England to have been unlawful (*Devon Partnership NHS Trust v Secretary of State for Health and Social Care* (January 2021); Dyer, 2021).

Under the MHA, applications for detention can only be made by an AMHP who has 'personally seen' the patient in a recent 14-day period (Section 11). Supporting medical recommendations must come from practitioners who have 'personally examined' the patient (Section 12). These provisions, at first glance, appear ambiguous as to whether assessments via videocall could meet the threshold of being 'personally seen' or 'examined'. In May 2020, prior to the High Court decision, NHS England (2020) and Department of Health and Social Care for England released guidance stating that 'the provisions of the Mental Health Act *do allow* for video assessments to occur' (emphasis added), but that '[e]ven during the COVID-19 pandemic it is always preferable to carry out a Mental Health Act assessment in person'. A caveat was added that 'providers should be aware that only courts can provide a definitive interpretation of the law' (NHS England, 2020).

Subsequently, the Devon Partnership NHS Trust sought clarification from the High Court, which found 'that the phrases "personally seen" in s. 11(5) and "personally examined" in s. 12(1) require the physical attendance of the person in question on the patient' (*Devon Partnership NHS Trust v Secretary of State for Health and Social Care* (January 2021) [s.62]). The court made clear that any change to the law in England and Wales on this matter would be for Parliament.

Subsequently, the Department of Health and Social Care (2021) released a white paper titled 'Reforming the Mental Health Act', which addressed the prospect of remote MHA assessments, among other issues. In a section on use of remote technology, the paper stated:

At the time of the White Paper's publication, the position of the Government and NHS [England and Improvement] was that the Act may be interpreted to allow for this. However, the High Court found otherwise.

In parallel ... the Government held discussions with stakeholders to consider whether the Act should be amended to allow ... for the use of remote assessments. We have decided not to do so. The broad consensus was that the presence of professionals in the room with people is required. It is in the interest of patients, and preserves established good practice.

(Department of Health and Social Care, 2021 [28])

During the period in which videocall assessments *were* being used, a survey of AMHPs by the British Association of Social Workers (BASW, 2020) looked at the impact of the COVID-19 pandemic on AMHP services. Several benefits of remote assessments were listed, including reducing the risk of COVID-19 infection for all concerned, undertaking out-of-area assessments over large distances, and being able to assess people in care homes that did not allow visitors (BASW, 2020, 29). Concerns were raised among the 100 AMHPs who were surveyed, 'that some professionals will want to use [digital technology during MHA assessments] "for convenience rather than necessity" and that '[i]t hampers effective communica-

tion, including the observation and assessment on non-verbal cues and behaviour' (BASW, 2020, 29). Reportedly, '[o]nly a small number of respondents felt that these assessments worked well' (BASW, 2020, 29).

Elsewhere in the UK, the potential for remote assessments during this time have been considered more favourably. In Scotland, the *Mental Health (Care and Treatment) (Scotland) Act 2003* does *not* require assessments to be conducted in person, yet the Code of Practice for the Act does appear to envision that detention assessments would be conducted face-toface in all circumstances (Scottish Executive, 2003 [parts 5, 6, 7 & 20]; noted in Schölin et al., 2021). The Mental Welfare Commission for Scotland has subsequently recommended that remote assessments *should* be permitted in limited circumstances; particularly for the renewal of a community treatment order, which 'might be preferably undertaken remotely with the consent of the patient' (Schölin et al., 2021, 604).

The recommendation is justified by 'the possibility of patients who have existing relationships with psychiatrists to have assessments undertaken remotely', again stressing that 'the method of assessment should not be forced on the patient, but respect the patient's preferences' (Schölin et al., 2021, 604). It is outside the scope of this chapter to consider the implications for law and practice in Scotland of this recommendation. Suffice to say that ethical and legal challenges remain, including with obtaining the informed consent of the person concerned (see Schölin et al., 2021), as well as with regard to the unique compulsory powers afforded by CTOs in community settings (Fennell, 2010), and what it might mean to extend forms of medical power via digital modes into peoples' homes and residences (see relatedly, Series, 2022; Crowther and McGregor, 2022).

Videoconferencing in tribunals that authorise involuntary psychiatric intervention

A third major area of digitisation was the increased use of videoconferencing software in the formal proceedings of mental health tribunals, a trend in no way unique to England and Wales. Since the COVID-19 pandemic began, remote hearings have ramped up in several countries, such as Scotland (Stavert and McKay, 2020), Australia (Wilson, 2020), and the US (Vitiello and Williams, 2021). In England and Wales, contingency planning was implemented for tribunals across the Courts and Tribunals Judiciary early in the pandemic (Rider, 2020). Practice directions required that hearings should be held remotely where it was reasonably practicable and in accordance with their overriding objective. This temporary directive did not appear to be extended beyond September 2021 (Wilson, 2022, 'Coronavirus' [s 1.5]).

An immediate question to be asked is whether the transition to remote tribunals impacted outcomes, such as discharge rates. According to the Care Quality Commission (2022, 66–67), it did not: the First-Tier Tribunal (Mental Health) continued to hear cases throughout the pandemic using remote hearings and the change 'to remote hearings appear[ed] to have had no effect on outcome, with similar proportions of discharges to hearings in 2020/21 compared to the previous year'.

Case law reveals some legal issues with the transition to remote hearings, particularly concerning access to justice. One case, Re D [2020] MHLO 51 (FTT) (a non-binding First-Tier Tribunal decision) involved the tribunal's decision being set aside because 'it was not clear whether or not the patient had a reasonable opportunity to hear all the evidence that was given at the hearing: it was not possible to be sure that the patient had a fair hearing' [4].

The patient's microphone had been muted for much of the time after giving her evidence at the outset because she 'would not stop talking' (*Re D* [2020] *MHLO* 51 (*FTT*) [4]). The judge suggested steps for ensuring a 'reasonable opportunity to hear all the evidence that was given', including going back to the person at the end of each witness statement to ensure that she had heard and understood the evidence given (*Re D* [2020] *MHLO* 51 (*FTT*) [4]).

In *GL v Elysium Healthcare [2020] UKUT 308 (AAC)*, a patient, GL, had his adjournment request refused and the tribunal proceeded with a telephone hearing in his absence. The Upper Tribunal determined that the tribunal's decision was unlawful because:

- 1. The tribunal had assumed that GL's flatmate (who was in a different room to the patient, behind a closed door, as they were both self-isolating due to COVID-19) would not overhear the proceedings [11].
- 2. The tribunal had disregarded or afforded too little weight to the patient's anxiety about being overheard or others learning his history. In the past, GL had been seriously assaulted by another patient who learned of his past offending. The tribunal should have considered whether his anxiety would have impacted his ability to participate [12].
- 3. The tribunal had wrongly approached GL's request as if he was concerned about the mode of hearing (via telephone) rather than the specific circumstances giving rise to the risk of being overheard [14].

The cases demonstrate that although discharge rates overall may not have been impacted by the move to remote hearings, there remained significant risks to procedural fairness with the move to remote hearings.

There is limited research on patient and clinician experiences of remote hearings. One (non-peer reviewed) survey conducted by the Mental Health Tribunal and the Royal College of Psychiatrists (2021a) recorded the views of 223 clinicians and 30 patients. Of the clinician respondents, 33% thought remote hearings were better for them – 'a more efficient use of clinical time' (Royal College of Psychiatrists, 2021a, 1). (What the remaining 57% of clinicians reported is unstated.) A total of 58% of clinicians reported that hearings were disrupted in some way due to technological issues and 29% reported that hearings had no disruption (Royal College of Psychiatrists, 2021a, 1). Clinicians gave examples of when they thought remote hearings would be useful, including: 'if the patient had indicated they would not attend, or could not attend (due to behaviour, being in seclusion or segration [sic]) and also [in instances in which] the patient was in a more familiar environment on the ward than in the tribunal room' (Royal College of Psychiatrists, 2021a, 2).

The 30 patients who provided feedback reported similar satisfaction with remote hearings as with face-to-face hearings (Royal College of Psychiatrists, 2021a); 40% of patient respondents reported no problems with technological issues (though it is not reported if the remaining patients reported disruption due to technological issues, or to what extent). Not all patients were aware of the process of a remote hearing. To improve patient experiences, the report authors recommended (Royal College of Psychiatrists, 2021a, 3):

- 1. The [Tribunal] panel to continue to ask order of evidence and reasonable adjustments from the [responsible clinician], patient and patient's representative;
- 2. Patients to be offered breaks during the hearing;
- 3. Information leaflets about remote hearings written by the Tribunal to be given to patients.

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These recommendations were to be integrated into Tribunal Members' training during 2021–2022, and the tenor of the document suggests an overall plan to continue remote hearings (for example, the report recommends that NHS Trusts invest in technology infrastructure for patients) (Royal College of Psychiatrists, 2021a, 2–3).

Videoconferencing in authorising involuntary psychiatric interventions: United States

By way of international comparison, in the US, the majority of civil commitment hearings were conducted remotely by the end of 2020 (Sorrentino et al., 2020). 'Remotely' entailed not simply videocalls with the relevant person, which have been used in varying ways since the 1990s (see e.g. American Psychiatric Association, 1998), but the entire courtroom meeting remotely, including judge and courtroom personnel (attorney, witnesses, and so on). When the pandemic began, the Judicial Conference of the US gave temporary approval to the use of video and telephone conferencing during COVID-19 civil commitment hearings, and indeed all civil proceedings (*Coronavirus Aid, Relief, and Economic Security Act. S. 3548, 116th Cong., 2d Sess. (2020) (enacted)*). The approval built upon a 2016 Position Statement by the American Psychiatric Association (APA, 2016), which argued that videoconferencing was an 'acceptable and cost-effective alternative that protects the privacy of the patient without compromising their due process rights'.

However, Evan Vitiello and Joseph Williams (2021, p. 610) highlight that 'courts have not been aligned with each other regarding the legality of a commitment tele-hearing arrangement'. They cite decisions in the US Fourth Circuit (*United States v. Baker*, 45 F.3d 837 (4th Cir. 1995)) and the Virginia Supreme Court (*Shellman v. Commonwealth of Virginia* (Va. 2012)) which offered support for a virtual commitment hearing format but contrast them with other courts that have restricted videoconferencing usage for commitment proceedings. For example, the Florida Supreme Court held that respondents have a veto on videoconferenced commitment hearings (*Doe v. State, 217 So. 3d 1020* (Fla. 2017)), and Oregon's Court of Appeals required trial courts to make a clear justification for holding a commitment hearing via videocall where the respondent objects to the format (*re G.N., 215 P.3d 902* (Or. Ct. App. 2009)). There has been no US Supreme Court ruling on the lawfulness of the remote mode of civil commitment hearings, nor on the procedural safeguards that might be required, reflecting a similar state of flux as in the UK and elsewhere.

Discussion: Reflections on technological experimentation and mental health law

Government agencies are increasingly adopting digital technological approaches to mediate the relationship between citizens and mental health services, including involuntary or coercive interventions. Even when the service user or person subject to intervention does not engage *directly* with such digital systems, such as app-based triaging and MHA practitioner payments like the *s12 Solutions* and *Thalamos*, the new systems directly shape people's experience of mental health law and practice. This may be for better, in improving service responsiveness, or it may be for worse, such as by increasing the potential for a person in crisis to be assessed by a clinician unknown to them.

Simultaneously, governments are attempting to regulate and govern the rapidly expanding technology sector in recognition of the ethico-legal issues these technologies raise.

According to some, these government efforts are hampered by narratives pushed by the technology industry that 'policymakers are people that don't understand the technology itself' (Jordan and Klein, 2020), and similar derisive claims are sometimes leveled at academics.

However, efforts to govern technological developments are occurring in the mental health context in a range of ways. In England and Wales, the High Court's recognition of the qualitative difference between in-person and videocall medical assessment concerning detention under the MHA is a prime example, as is the subsequent consultation by the Department of Health and Social Care that demurred from recommending legislative change to allow remote assessments. The decision by the Mental Welfare Commission for Scotland to allow remote assessment for consenting adults on CTOs is noteworthy, and questions are likely to be raised regarding the affordances of digital technologies in extending processes of coercive intervention in the community. Another example of active governance is the temporary contingency measures to allow for remote Mental Health Tribunal hearings under Section 3 of the Tribunals, Courts and Enforcement Act 2007 (England and Wales), which was time-limited, being initially authorised for six months, with options to renew or revoke at any time should it become inappropriate or unnecessary (Byrom and Beardon, 2021 [2.5]). Courts appear to be taking a precautionary approach, identifying that a fair trial clearly requires that a person can fully engage in the remote hearing process. This sentiment was articulated by the judge in Re D [2020] (MHLO 51 (FTT)), who highlighted 'the difficulty for all concerned of managing hearings on video, and the extra care that needs to be taken by all participants to ensure that justice is being done consistently'.

Regarding the use of apps or digital platforms for professionals conducting MHA assessment setup and claim form processes, it is perhaps slightly harder to identify levers for responsible governance and oversight – at least from a legal perspective. This is not to suggest that the courts or tribunals in the UK have 'got it right' in exercising oversight of remote medical assessments or hearings; rather, it is to say that the levers in law for governing such processes are readily apparent. This seems to be less the case regarding the 'app-ification' or 'platformisation' of mental health crisis work.

The apps or platforms discussed earlier in the chapter are not subject to direct oversight by the mental health tribunals and tend not to be characterised as enabling a direct application of the MHA in the way assessments and hearings do. Instead, the use of apps and platforms to set up MHA assessment are viewed in policy terms as facilitating the administration of practitioner activity or as 'workforce development', as one report suggests (Stevens et al., 2022). Yet, as discussed above, safety issues and concerns about the rights of those subject to interventions via the app remain, and these real or potential harms may be missed by such an administrative framing. Nor does it appear that the application of the platform model in public policy is necessarily well understood (Faulkner-Gurstein and Wyatt, 2021), posing barriers to transparency and scrutiny. Procurement and commissioning processes may constitute a 'soft law' lever for governments to balance their role as regulators and procurers of emerging technologies and innovations in mental health crisis work. Procurement processes have also been a site for civil society representatives such as professional associations or service user advocacy groups to direct their attention, as the next section will note. However, serious issues have emerged on these fronts, with evidence that the NHS's current procurement and commissioning arrangements, particularly involving data-driven approaches to mental health law, are far from ideal.

Safety and accountability amid digitisation and privatisation

The reported description of *s12 Solutions* by an NHS Trust Executive as the 'Uber of finding doctors for the health service' is striking. Uber is synonymous with disruptive 'platform' businesses that, at least in one major iteration of the digital platform, connect 'producers' and 'consumers'/platform users (Faulkner-Gurstein and Wyatt, 2021). The comment is perhaps indicative of the alignment between the use of digital technology in government agencies and trends to privatise health and social services, including a growing reliance on the private sector to solve problems, especially through technological means (Petersen, 2018, pp. 66–77).

s12 Solutions was founded by an AMHP herself who was reportedly frustrated with the inefficient MHA communication process between relevant professionals (Stevens et al., 2022). More recently, the company was acquired by a larger, for-profit electronic health records company (Matlow, 2021) in an acquisition deal reportedly worth USD\$8.23M ('\$12 Solutions Company Profile,' n.d.). The business was originally supported with funding from the NHS Innovation Accelerator, as well as other sub-programmes of NHS England, including its Innovation and Technology Payment Evidence Generation Fund, NHS England's Clinical Entrepreneur programme, and DigitalHealth.London's Accelerator (s12 Solutions, 2022), helping to secure the programmes reported uptake in 75% of NHS Trusts.

The involvement of the private sector in the NHS is a hotly contested topic, and beyond the scope of this paper. However, I will briefly consider the concern of some commentators that traditional accountability measures may be ill-equipped to ensure private digital technology providers align with the public good, particularly where the divide between public and private entities becomes blurred (United Nations General Assembly, 2018). These possibilities, at a minimum, seem important to articulate, especially where for-profit entities are taking a role in digitising processes that involve restrictions on a person's liberty, legal capacity, autonomy, and other fundamental rights, as occurs with involuntary psychiatric intervention.

Philip Alston, the former UN 'Special Rapporteur on extreme poverty and human rights', has raised concerns about digitisation in the provision of social and healthcare services more generally; he argues that growing privatisation, often accompanied by processes of digitisation, has rendered existing mechanisms of accountability increasingly marginal (United Nations General Assembly, 2018). The rise of private sector actors in social protection services, according to Alston, has been accompanied by a 'deeply problematic lack of information about the precise role and responsibility of private actors in proposing, developing and operating digital technologies in welfare states around the world' (United Nations General Assembly, 2019). The current UN Special Rapporteur for the Rights of Persons with Disabilities, Gerard Quinn, has argued that government funding for digital initiatives in the disability context – including mental health services – should be dependent upon submissions regarding stringent evidence of safety and efficacy, and in accordance with human rights (Human Rights Council, 2021). Quinn's and Alston's comments are general in nature, and I am not suggesting in any way that the companies discussed earlier in this paper have acted improperly.

Where serious concerns *can* be raised is with the NHS-managed public-private partnerships that have helped to resource such digital platform companies, and the ecosystem of public-private entities from which they emerge. For example, in 2021, the Royal College of Psychiatrists (UK) called for an 'urgent and transparent investigation' into the 'NHS Innovation Accelerator' and Academic Health Science Network, both of which have provided financial and institutional support to *s12 Solutions, Thalamos*, and other for-profit oper-

ators concerning digitised MHA arrangements (see NHS England, n.d.). Public concerns about these quasi-government entities related specifically to a programme called 'Serenity Integrated Mentoring'.

Serenity Integrated Mentoring: A case study in the perils of innovation-speak

'Serenity Integrated Mentoring' (or SIM) was a programme run in England by police and public mental health services directed at individuals who are frequently detained under section 136 of the MHA (Jackson and Brewster, 2018). Such individuals were defined by the private company behind SIM as 'high intensity users' (Jackson and Brewster, 2018). The SIM programme involved police and mental health crisis services collaborating to develop 'case management plans that allowed a seamless move from offers of therapeutic engagement (by the mental health team) to use of coercive measures (by the police) with those who persisted with frequent crisis presentations' (House, 2022, p. 1). The individuals were chosen based on local health authority MHA data for the previous year to 'define which borough/geographical area had the highest proportion of high intensity users of [Section] 136' (Jackson and Brewster, 2018, 6). SIM did not use app-based technology, though a key component of the programme was electronic health records being shared between government agencies that were used to flag individuals in emergency service encounters.

In May 2021, major concerns were reported about the programme following advocacy by a service user-led group, the StopSIM Coalition (n.d.). According to one media report:

When tagged under the system, patients can be denied care, prevented from seeing doctors or psychiatrists, and sent home. An NHS doctor told [media] that he had to turn away a woman who had attempted suicide on multiple occasions because she had been assigned to the SIM scheme. He considered resigning as a result.

(Strudwick, 2021)

The Royal College of Psychiatrists (2021) released a highly critical statement about the programme, reporting that:

[where a person] remained unwell and continued to self-harm, attempt suicide or report suicidality, in some cases they were prosecuted and imprisoned or community protection notices were applied which required them to stop self-harming or calling for help, with imprisonment as a potential sanction if they breached the notice.

The StopSIM coalition raised three major concerns: the harm of police contact and criminalisation of those in crisis, application of the 'mentoring' without the free and informed consent of the person, and sharing of confidential information with police (House, 2022).

Concerning data protection, StopSIM charged that the programme 'allows "sensitive data" (information like medical records, ethnicity, religion, sexuality, gender reassignment and financial information) to be shared between services without the subject's consent ... (for example, as a consequence of calling [emergency services] when feeling suicidal)' (StopSIM Coalition, n.d.). This claim was denied by the company (Moreton, 2021), and steps towards General Data Protection Regulation (GDPR) compliance were outlined in early NHS programme material (Jackson and Brewster, 2018, 5). However, Allan House (2022, p. 2) has reported troubling evidence of what he described as the company's 'authoritarian' approach

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to sharing confidential clinical data. 'Crisis plans' were developed by sharing clinical information with police at any time, because patients in the scheme were portrayed as 'constantly an emergency case' – conceivably circumventing GDPR restrictions on non-urgent data sharing – and staff were instructed to 'please don't tell the patient they have any right to choose who reads it. Know your GDPR' (cited in House, 2022, p. 2).

These are very serious allegations, and an NHS-led investigation is underway at the time of writing to clarify precisely what happened, as noted below. Regardless, by 2021, the SIM programme had been reportedly rolled out to 23 NHS mental health trusts and 18 police forces in England (Moreton, 2021). The programme had expanded with the institutional and financial support of the NHS Innovation Accelerator programme and the NHS-managed Academic Health Science Networks. The company director behind SIM was made an 'NHS Innovation Accelerator Fellow', which entitles recipients to financial and institutional support 'to further scale [Fellows'] promising innovations' (Ducey, 2018); and the NHS had commissioned the Academic Health Science Networks to 'support the spread and adoption of SIM' between April 2018 and March 2020 ('AHSN Network statement on SIM (Serenity Integrated Mentoring)', 2021).

This rollout occurred despite a lack of robust assessment of impact on patient safety or outcomes (Royal College of Psychiatrists, 2021). Instead, research by the Academic Health Science Network – again, a public-private entity – focused principally on SIM's impact on cost minimisation, with a small number of descriptive case studies (see e.g. Health Innovation Network South London, 2020). The Academic Health Science Networks are self-described in one such report as 'the only bodies that connect NHS and academic organisations, local authorities, the third sector and industry' and as 'catalysts that create the right conditions to facilitate change across whole health and social care economies, with a clear focus on improving outcomes for patients' (Health Innovation Network South London, 2020).

The SIM programme was also the recipient of several awards within a broader eco-system of for-profit entities concerned with privatisation and healthcare technology. This included a 'Patient Safety Award' by the *Health Service Journal* (2017) (not to be confused with the academic *Health Services Journal*), a UK online media company that is a subsidiary of a private consulting firm that advertises its role in 'NHS Service Improvement' through '[c] onsultancy services, and bespoke insights and analytics, designed to improve patient experiences and market access' (Wilmington Healthcare, 2022).

After concerted advocacy by the StopSIM coalition and others, the company behind the SIM programme appears to have closed permanently; its website was removed and its social media presence wiped.³ An overarching concern of the StopSIM coalition was that outsourcing service provision to a private company meant the programme fell between gaps of traditional accountability mechanisms (StopSIM Coalition, n.d.):

Usually when a new treatment is introduced into the NHS there is a careful process of checking that it is safe and effective before it is rolled out to patients. This includes trialling it with a small number of people and assessing how well it meets their needs as well as catching any unintended consequences or side effects. SIM bypassed this process by being sold as an 'innovation' or 'quality improvement' measure and so research into the safety and effects of SIM has not been done.

³ An archived version of the Network website is available here: https://web.archive.org/web/20201126102513 /https://highintensitynetwork.org/ (accessed 25/08/21).

At the time of writing, the National Clinical Director for Mental Health has directed NHS Mental Health Trusts to review their use of SIM (AHSN Network, 2022). It is unclear whether this review will extend to the role of the NHS Innovation Accelerator and Academic Health Science Network, as recommended by the Royal College of Psychiatrists and the StopSIM coalition.

Governing sociotechnical systems in the public interest: Finding the right(s) framework?

In providing an account of SIM, I am not suggesting that this programme is at all comparable in nature or in terms of the harms it has caused, to the digital platforms discussed earlier that assist professionals to conduct MHA assessments. Instead, I am suggesting that the current NHS procurement and commissioning of private sector practices concerning mental health crisis work – particularly through the NHS Innovation Accelerator and Academic Health Science Network, which again have provided institutional resources to promote the widespread uptake of the apps/platforms noted earlier – appear manifestly inadequate. These concerns align with critiques of accountability deficits common to privatisation and digitisation of public services, noted above.

This situation is clearly unsatisfactory in terms of the rights of those engaging with public mental health services, but nor would it seem desirable to those wishing to innovate mental health crisis work in good faith. This latter group are likely to want robust evidentiary and safety requirements that have the confidence of service user groups and professional associations alike, among others – a confidence that does not appear to be enjoyed by public-private partnerships like Academic Health Science Networks or the NHS Accelerator, at least at present.

Currently, some parts of the programme evaluations conducted by the Academic Health Science Networks tend to read like promotional material rather than rigorous and independent research. As one example, an evaluation of the s12 Solutions app by the Wessex Academic Health Science Network (2020 s.11.3), contains a section on the UK's General Data Protection Regulation, which is established by the Data Protection Act 2018 (UK). This is likely to be a core domestic legal concern regarding the digitisation of health services. The evaluators first list the data protection issues of the traditional AMHP system, which arise because paper- or email-based forms pass by numerous individuals and in multiple settings (Wessex Academic Health Science Network, 2020, 68). In contrast, the s12 Solutions app presents a standardised claim form that is sent directly to the claim form processor. This is straightforward enough, yet the authors go on to state that '[t]herefore, patient and staff privacy are maintained and the risk of a GDPR breach is eliminated' (Wessex Academic Health Science Network, 2020, 68 (emphasis added)). This conclusion is overstated and unrealistic. GDPR compliance only every aims to minimise - not eliminate - the risk of personal data breaches.⁴ 'Data controllers' under the Data Protection Act 2018, s102(b), for example, are required to 'implement appropriate technical and organi-

⁴ Notably, the authors refer to a 'GDPR breach', which is arguably narrower than a 'data breach'. A personal data breach might not lead to a breach of the GDPR if the principles of the Data Protection Act 2018 are followed (for example, there is no 'GDPR breach' in the strict sense where the controller informs the data subject of the data breach without undue delay (Data Protection Act 2018 s68(1)). However, it doesn't appear that this is the

sational measures ... to ensure that ... risks to the rights and freedoms of data subjects are minimised'. This may be a minor issue of expression in an otherwise large report. Yet, in the context of the safety and accountability failures of the SIM programme, and broader concerns about for-profit data intermediaries in British healthcare (Faulkner-Gurstein and Wyatt, 2021) and internationally (United Nations General Assembly, 2018), the error is troubling.

Several issues warrant further exploration amid these broader changes. One is the impact of electronic health records, which are subject to a growing body of evidence showing how they create new practices and workflows, often unexpectedly (Kariotis et al., 2022; Ventres et al., 2006). For example, structured data entry forms can disrupt the inclusion of narrative information (Kariotis et al., 2022), and the potential for AMHPs using apps to opt for MHA assessors based on convenience rather than familiarity with the person, is another example of a potentially adverse outcome (albeit a speculative one). Scholarship on electronic health records is relatively sparse in the mental health context (Kariotis et al., 2022) but could inform legal and policy arrangements for digitised mental health crisis support. Certainly, Academic Health Science Network evaluations have highlighted *improvements* in workflow created by the electronic record keeping of triage apps (Health Innovation Network South London, 2020), and promising evidence has emerged from subsequent scholarly evaluations (Stevens et al., 2022), but little attention has been paid to potentially adverse impacts on workflow, which have only started to be explored (BASW, 2020; Stevens et al., 2022).

Efforts to strengthen transparency and scrutiny over for-profit data intermediaries have also included analysing 'platformisation' more generally, particularly in the context of public policy. Rachel Faulkner-Gurstein and David Wyatt (2021) make a compelling case that the NHS itself is being managed as a sort of platform, in which the organisational form and operational logic of digital platforms is applied to public services. Although it is beyond scope to outline their argument, they offer techniques for analysing the heterogenous range of platforms in the public policy context – their function, beneficiaries, and data usages – which could inform the development of governance levers in law and policy. Faulkner-Gurstein and Wyatt (2021, p. 16) capture the 'dualistic conception of the public benefit' underlying the digital transformation of English and Welsh health services, which is 'conceived both in medical and economic terms':

The platform ... model has facilitated the development of new treatments and medicines, potentially leading to better patient outcomes. But platformization also extends the notion of public benefit into murky areas where developing a research infrastructure uses the strategies of private firms. ... [P]latformization makes these intertwined logics difficult to evaluate. The delegation of authority to private firms means that some public funds and resource are supporting private profit-making. And yet as part of the platform, these private initiatives attempt to define themselves as part of the public good.

Risks emerging from this entwinement include public resources being appropriated by private-sector technology and other firms, and the delegation of accountability to private firms

meaning adopted by the evaluation authors as the report's conclusion includes the more tempered statement that the programme 'significantly reduces the opportunity for GDPR breaches' (p. 78).

in opaque ways. Benefits will also emerge, but they remain largely promissory and speculative. The balance sheet is yet to be written.

Finally, the inclusion of people with lived experiences (or lack thereof) in the development, implementation, and oversight of digital data-driven mental health services requires further examination (Carr, 2020); and little appears to be known about service user views on many of the developments discussed in this chapter, with notable exceptions (see Tomison 2021). This conforms with broader patterns in research into data-driven and algorithmic technology in mental healthcare, which shows troublingly low levels of involvement – let alone partnership with, or leadership – of service user perspectives (Gooding and Kariotis, 2021).

Conclusion

The world is facing the app-ification of mental healthcare and the Uber-isation of the mental health profession (Zeavin, 2021). The extent and form of this potential change remains uncertain, as does its impact on processes of involuntary psychiatric intervention. Yet, 'digital mental health services' have clear coercive potential (Butorac and Carter, 2021) and experimentation is underway (see Gooding, 2019). Sarah Carr (2020, p. 125) describes the significance of these changes when she writes that:

Possibly more than any other group of patients, people with mental health problems can experience particular forms of power and authority in service systems and treatment ... The implications of these specific power dynamics as well as potential biases in mental health systems must be considered for the ethical development and implementation of any data-driven technology in mental health.

Global economic downturns and fiscal constraint will increase pressures on health systems to minimise costs, to which technological solutions will be invariably proposed. A common appeal lies in expected efficiency gains and improved services for those who want or are deemed to need them. It is hard to object to cutting down wait times in service provision for those in extreme crisis, or allowing a person to seek advocacy or access remote tribunal hearings where it suits them, including through high-quality internet facilities in acute public mental health settings (see e.g. Care Quality Commission, 2022). At the same time, many of these aims are tied to economic and political interests concerned with cost minimisation, privatisation, and the generation of capital through data accumulation and the uptake of apps, driven by expectations of the economic value attributed to platforms and data (Crawford, 2021; Faulkner-Gurstein and Wyatt, 2021).

For those concerned with mental health-related law, it will be difficult to avoid entering this thicket as the 21st century rolls on. And one needn't contemplate utopian or dystopian visions of the future to do so – there is much to get on with today.

References

American Psychiatric Association (1998). Telepsychiatry via videoconferencing resource document [Internet]. https://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.173.2939&rep=rep1&type =pdf (accessed 5/5/22)

American Psychiatric Association (2016). Position statement on location of civil commitment hearings [Internet]. https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-2016-Location-of-Civil-Commitment-Hearings.pdf (accessed 5/5/2022)

Legislation

Data Protection Act 2018. GOV.UK. https://www.legislation.gov.uk/ukpga/2018/12/pdfs/ukpga _20180012_en.pdf

Mental Health Act 1983 (England and Wales). Queen's printer of Acts of Parliament. https://www.legislation.gov.uk/ukpga/1983/20/contents

Mental Health (Care and Treatment) (Scotland) Act 2003 asp 13. Acts of the Scottish Parliament. https://www.legislation.gov.uk/asp/2003/13/contents

The Mental Health (Hospital, Guardianship and Treatment) (England) (Amendment) Regulations 2020 (2020). Queen's printer of Acts of Parliament. https://www.legislation.gov.uk/uksi/2020 /1072/made

Case Law

United Kingdom

GL v Elysium Healthcare [2020] UKUT, 308 (AAC) Re, D. [2020] MHLO 51 (FTT)

United States

Doe v. State, 217 So. 3d 1020 (Fla. 2017) re G.N., 215 P.3d 902 (Or. Ct. App. 2009) Shellman v. Commonwealth of Virginia (Va. 2012) United States v. Baker, 45 F.3d 837 (4th Cir. 1995)

Literature

- AHSN Network (2022). Freedom of Information (FOI) Requests. AHSN Network. https://www.ahsn-network.com/freedom-of-information-foi-requests
- AHSN Network Statement on SIM (Serenity Integrated Mentoring). (June 2021). AHSN Network. https://www.ahsnnetwork.com/ahsn-network-statement-on-sim-serenity-integrated-mentoring
- BASW (2020). The Impact of the Covid-19 Pandemic on Approved Mental Health Professional (AMHP) Services in England. https://www.basw.co.uk/system/files/resources/amhp_covid-19_report _2020.pdf

Baxter, G., & Sommerville, I. (2011). Socio-technical systems: From design methods to systems engineering. *Interacting with Computers*, 23(1), 4–17. https://doi.org/10.1016/j.intcom.2010.07.003

Bossewitch, J.S. (2016). Dangerous Gifts: Towards a New Wave of Mad Resistance. Columbia University. https://doi.org/10.7916/D8RJ4JFB

Brock, D. (2019). Los Angeles Review of Books. https://lareviewofbooks.org

- Butorac, I., & Carter, A. (2021). The coercive potential of digital mental health. *The American Journal of Bioethics*, 21(7), 28–30. https://doi.org/10.1080/15265161.2021.1926582
- Byrom, N., & Beardon, S. (2021). Understanding the Impact of COVID-19 on Tribunals: The Experience of Tribunal Judges. Tribunals Judiciary. https://www.judiciary.uk/wp-content/uploads/2021/06 /2021_06_02_REPORT_Understanding-the-impact-of-COVID-19-on-tribunals-the-experiences -of-judges-1.pdf
- Care Quality Commission (2022). Monitoring the Mental Health Act in 2020/21. Controller of Her Majesty's Stationery Office.
- Carr, S. (2020). 'AI gone mental': Engagement and ethics in data-driven technology for mental health. *Journal of Mental Health*, 29(2), 125–30. https://doi.org/10.1080/09638237.2020.1714011
- Corbyn, Z. (2021). The dawn of tappigraphy: Does your smartphone know how you feel before you do? *The Observer*. https://www.theguardian.com/technology/2021/nov/07/the-dawn-of-tappigraphy-does-your-smartphone-know-how-you-feel-before-you-do
- Cosgrove, L., Karter, J., Mcginley, M., & Morrill, Z. (2020). Digital phenotyping and digital psychotropic drugs: Mental health surveillance tools that threaten human rights. *Health and Human Rights Journal*, 22(2), 33–39.

- Crawford, K. (2021). The Atlas of AI: Power, Politics, and the Planetary Costs of Artificial Intelligence. Yale University Press.
- Crowther, N., & McGregor, L. (2022). A Digital Cage Is Still a Cage: How Can New and Emerging Digital Technologies Advance, Rather Than Put at Risk, the Human Rights of Older People Who Draw on Social Care? University of Essex.
- Dagum, P. (2018). Digital biomarkers of cognitive function. NPJ Digital Medicine, 1, 1–3. https:// doi.org/10.1038/s41746-018-0018-4
- Department of Health and Social Care (2021). Reforming the Mental Health Act: Government response. GOV.UK. https://www.gov.uk/government/consultations/reforming-the-mental-health-act/ outcome/reforming-the-mental-health-act-government-response
- Department of Health and Social Care (2020). Explanatory Memorandum to the Mental Health (Hospital, Guardianship and Treatment) (England) (Amendment) Regulations 2020 (No. 1072). HM Government.
- Ducey, H. (2018). Understanding how and why the NHS adopts innovation: Serenity integrated mentoring in Surrey. NHS innovation accelerator. https://nhsaccelerator.com/insight/understanding -nhs-adopts-innovation-serenity-integrated-mentoring-surrey/
- Dyer, C. (2021). Mental Health Act: Doctors should not use video assessments to detain patients during pandemic, say judges. *BMJ*, 372, n228. https://doi.org/10.1136/bmj.n228
- Faulkner-Gurstein, R.F., & Wyatt, D. (2021). Platform NHS: Reconfiguring a public service in the age of digital capitalism. *Science, Technology and Human Values*. Online First. https://doi.org/10.1177 /01622439211055697
- Fennell, P.W.H. (2010). Institutionalising the community: The codification of clinical authority and the limitations of rights based approaches. In McSherry, B., & Weller, P. (Eds.), *Rethinking Rights-Based Mental Health Laws*, (13–50). Hart Publishing
- Gooding, P. (2019). Mapping the rise of digital mental health technologies: Emerging issues for law and society. *International Journal of Law and Psychiatry*, 67, 101498. https://doi.org/10.1016/j. ijlp.2019.101498
- Gooding, P., & Kariotis, T. (2021). Ethics and law in research on algorithmic and data-driven technology in mental health care: Scoping review. *JMIR Mental Health*, 8(6), e24668. https://doi.org/10.2196/24668
- Hamilton, I.A. (2019). Elon Musk said his AI-brain-chips company could "solve" autism and schizophrenia. Business insider Australia. https://www.businessinsider.com.au/elon-musk-said-neuralink -could-solve-autism-and-schizophrenia-2019-11
- Health Innovation Network South London (2020). SIM London: Support for a Better Life (April 2018–2020). Academic Health Science Network.
- Health Service Journal (2017). HSJ patient safety awards 2017: Managing long term conditions. HSJ.co.uk. https://www.hsj.co.uk/patient-safety/hsj-patient-safety-awards-2017-managing-long -term-conditions/7018933.article
- HM Government (2018). Modernising the Mental Health Act: Increasing Choice, Reducing Compulsion: Final Report of the Independent Review of the Mental Health Act 1983. Crown.
- Horgan, J. (2021). Premature Freak-Outs about Techno-Enhancement. Scientific American.
- House, A. (2022). Serenity integrated mentoring and the high intensity network: A scheme that raises serious questions for practice and governance in UK psychiatry. *BJPsych Bulletin*, 1–4. https://doi. org/10.1192/bjb.2022.6
- Human Rights Council (2021). Report of the special rapporteur on the rights of persons with disabilities (UN Doc A/HRC/49/52).
- Jackson, A., & Brewster, J. (2018). The implementation of SIM London: Sharing best practice for spread and adoption. Health Innovation Network: South London.
- Jordan, A., & Klein, N. (2020). Branding, privacy, and identity: Growing up in surveillance capitalism. Journal of Children and Media, 14(2), 259–266. https://doi.org/10.1080/17482798.2020.173 5148
- Kariotis, T.C., Prictor, M., Chang, S., & Gray, K. (2022). Impact of electronic health records on information practices in mental health contexts: Scoping review. *Journal of Medical Internet Research*, 24(5), e30405. https://doi.org/10.2196/30405
- Matlow, D. (2021). Vitalhub signs S12 contract with Northamptonshire. Stockwatch.com. https://www.stockwatch.com/News/Item/Z-C!VHI-3184892/C/VHI.

McQuillan, D. (2018). Mental health and artificial intelligence: Losing your voice. openDemocracy.

Mental elf (2020). Digitising the Mental Health Act: A Public Debate #DigitalMHA

- Metz, R. (2018). The smartphone app that can tell you're depressed before you know it yourself. *MIT's Technology Review*. https://www.technologyreview.com/2018/10/15/66443/the-smartphone -app-that-can-tell-youre-depressed-before-you-know-it-yourself/
- Moreton, S. (2021). ACP-UK rapid response: Concerns about the high intensity network (HIN) and serenity integrated mentoring (SIM). ACP UK. https://acpuk.org.uk/rapid-response-concerns -about-the-high-intensity-network-hin-and-serenity-integrated-mentoring-sim-2/
- Murtha, J. (2018). Jeff Bezos's VC arm contributes to mindstrong's \$15M round. Chief healthcare executive. https://www.chiefhealthcareexecutive.com/view/jeff-bezoss-vc-arm-contributes-to -mindstrongs-15m-round
- NIMH National Institute of Mental Health. (2019). NIMH » Technology and the future of mental health treatment.

NHS England (2020). Legal guidance for mental health, learning disability and Autism, and specialised commissioning services supporting people of all ages during the coronavirus pandemic: Version 2 (publications approval reference: 001559). National Health Service.

- NHS England (n.d.). Innovations. NHS innovation accelerator. https://nhsaccelerator.com/ innovations/
- Petersen, A. (2018). Digital Health and Technological Promise: A Sociological Inquiry. Routledge.
- Reardon, S. (2017). Former US mental-health chief leaves Google for start-up. Nature. https://doi. org/10.1038/nature.2017.21976
- Rider, E. (2020). Pilot practice direction: contingency arrangements in the first-tier tribunal and the upper tribunal. Courts and Tribunals Judiciary. England and Wales.
- Royal College of Psychiatrists (2021a). Patient and clinician feedback about remote mental health tribunal hearings. https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental -health-policy/reforming-the-mental-health-act/remote-mht-research
- Royal College of Psychiatrists (2021b). RCPsych calls for urgent and transparent investigation into NHS innovation accelerator and AHSN following HIN suspension. https://www.rcpsych.ac.uk /news-and-features/latest-news/detail/2021/06/14/rcpsych-calls-for-urgent-and-transparent -investigation-into-nhs-innovation-accelerator-and-ahsn-following-hin-suspension
- S12 Solutions (2020). S12 and David Bradley: Chief Exec of the South London and Maudsley NHS Trust.
- S12 Solutions (2022). S12 Solutions. https://s12solutions.com/ (accessed 3/4/2022)
- S12 Solutions (n.d.). Company profile: Acquisition & investors | PitchBook. Pitchbook.com. https:// pitchbook.com/profiles/company/437312-35
- Series, L. (2022). Deprivation of Liberty in the Shadows of the Institution, Law, Society, Policy. Bristol University Press.
- Schölin L, Connolly M, Morgan G, et al. (2021). Limits of remote working: The ethical challenges in conducting Mental Health Act assessments during.
- Scottish Executive. Mental health (Care and Treatment) (Scotland) Act 2003 Code of Practice Volume 2 Civil compulsory powers.
- Socio-Technical System (n.d.). Oxford reference. https://doi.org/10.1093/oi/ authority.20110803100515814
- Sorrentino, R.M., DiCola, L.A., & Friedman, S.H. (2020). COVID-19, civil commitment, and ethics. Journal of the American Academy of Psychiatry and the Law, 48(4), 436. https://doi.org/10.29158 /JAAPL.200080-20
- Stavert, J., & McKay, C. (2020). Scottish mental health and capacity law: The normal, pandemic and 'new normal'. *International Journal of Law and Psychiatry*, 71, 101593. https://doi.org/10.1016 /j.ijlp.2020.101593
- Stevens, M., Martineau, S., Manthorpe, J., Steils, N., & Bramley, S. (2020). The Availability of Section 12 Doctors for Mental Health Act Assessments: A Scoping Review of the Literature. King's College London. https://doi.org/10.18742/PUB01-037
- Stevens, M., Martineau, S., Steils, N., & Manthorpe, J. (2022). The Availability of Section 12 Doctors for Mental Health Act Assessments: Interview Perceptions and Analysis of the National MHA Approvals Register Database. King's College London. https://doi.org/10.18742/PUB01-072
- StopSIM Coalition (n.d.). STOPSIM. https://stopsim.co.uk/

- Strudwick, P. (2021). Campaigners call for inquiry after mental health patients turned away by NHS under controversial scheme I.
- Thalamos (2022a). Thalamos. https://www.thalamos.co.uk/ (accessed 3/4/2022)
- Thalamos (2022b). Thalamos, 'Our Approach'. https://www.thalamos.co.uk/about/our-approach/ (accessed 3/4/2022)
- Teräs, M., Suoranta, J., Teräs, H., & Curcher, M. (2020). Post-Covid-19 education and education technology 'solutionism': A seller's market. *Postdigital Science and Education*, 2(3), 863–78. https://doi.org/10.1007/s42438-020-00164-x
- The Medical Futurist (2019). Artificial intelligence in mental health care. *The Medical Futurist*. https://medicalfuturist.com/artificial-intelligence-in-mental-health-care
- Tomison, A. (2021). Recognising the importance of responsible innovation: How Thalamos is developing clinical safety and lived experience by design. *Thalamos*. https://www.thalamos.co.uk/2021 /08/12/recognising-the-importance-of-responsible-innovation-how-thalamos-is-developing-clinical-safety-and-lived-experience-by-design/
- United Nations General Assembly (2019). Report of the special rapporteur on extreme poverty and human rights 11 October (No. A/74/493).
- United Nations General Assembly (2018). Report of the special rapporteur on extreme poverty and human rights 26 September (No. A/73/396).
- Ventres, W., Kooienga, S., Vuckovic, N., Marlin, R., Nygren, P., & Stewart, V. (2006). Physicians, patients, and the electronic health record: An ethnographic analysis. *Annals of Family Medicine*, 4(2), 124–31. https://doi.org/10.1370/afm.425
- Vitiello, E.M., & Williams, J.B. (2021). Videoconferencing of involuntary commitment hearings in the COVID Era. Journal of the American Academy of Psychiatry and the Law Online, 49(4), 610–17. https://doi:10.29158/JAAPL.210032-21
- Wessex Academic Health Science Network (2020). Independent Evaluation of the S12 Solutions Platform in Hampshire and Southampton. National Health Service.
- Wilmington Healthcare (2022). What we do | Wilmington healthcare. https://wilmingtonhealthcare. com/what-we-do/
- Wilson, J. (2022). Mental health law online: Annual review 2021.
- Wilson, K. (2020). The COVID-19 pandemic and the human rights of persons with mental and cognitive impairments subject to coercive powers in Australia. *International Journal of Law and Psychiatry*, 73, 101605. https://doi.org/10.1016/j.ijlp.2020.101605
- Zeavin, H. (2021). The Distance Cure: A History of Teletherapy. MIT Press.