

**Identity, risk and control: The perceptions of service users subject to section 37/41 of the Mental Health Act 1983 towards risk, risk assessment and social supervision.**

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## ***Abstract***

Whilst risk assessments have come to assume an increased level of importance in mental health policy and practice in England and Wales since the 1990s, there has been relatively little focus on the way in which service users themselves experience such practices. This thesis examines the views of offenders subject to Ministry of Justice restrictions under section 41 of the Mental Health Act 1983 towards their own offending, risk assessments and supervision. A primarily qualitative methodology is used to examine the views of 19 service users. Using theories of identity, the thesis examines the way that research participants explained and justified offending behaviour. It is argued that mentally disordered offenders used illness as a form of mitigation, utilised 'techniques of neutralisation' or employed a combination of these approaches. The thesis moves on to use governmentality theory as a means to analyse participants' awareness and views toward risk assessment practices and their conditions of discharge. Although participants believed that assessments were seen as important by mental health professionals, they were often unaware of the content of such assessments. Research participants usually had little or no knowledge of their conditions of discharge. Service user perceptions of the supervision process are then examined with reference to theories of social control. It is argued that service users held a range of views towards the supervision order, seeing it variously as a means of identifying and supporting them as mentally ill individuals; as a means of establishing internal controls or as a negative means of labelling socially stigmatised behaviours. The thesis concludes through considering the ways in which social workers might consider the use of risk assessment practices through an ethical framework. It is argued that social workers should seek to bridge Kantian and utilitarian perspectives through a consideration of service user autonomy.

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## ***Abbreviations Used***

AMHP – Approved Mental Health Professional

ASW – Approved Social Worker

BASW – British Association of Social Workers

BSA – British Sociological Association

CPA – Care Programme Approach

CPN – Community Psychiatric Nurse

DOH – Department of Health

GSCC – General Social Care Council

HONOS – Health of the Nation Outcome Scales

LA – Local Authority

MAPPA – Multi Agency Protection Panel Arrangements

MHA – Mental Health Act 1983 (as amended by the Mental Health Act 2007)

MHRT – Mental Health Review Tribunal

MOJ – Ministry of Justice

NHS – National Health Service

NICE – National Institute for Clinical Excellence

RC – Responsible Clinician

REC – Research Ethics Committee

RMO – Responsible Medical Officer

RSU – Regional Secure Unit

SRA – Social Research Association

UK – United Kingdom

## ***Chapter One – Introduction***

This thesis focuses on the views of mentally disordered offenders who have committed serious offences. The group in question were subject to social and psychiatric supervision due to their perceived risk toward others. The research presented explores the way in which this group conceptualised their risk. In order to address this question five research questions were posed. These were:

- How do service users' view their own offending behaviour and how does this impact on their own sense of identity?
- Do service users subject to section 41 of the Mental Health Act 1983 (MHA) in the community view themselves as being a risk and do they believe that they have constituted a risk in the past?
- Are service users aware of how their risk is conceptualised by their multi-disciplinary team?
- How far do service users' perceptions of their own risk vary from that of the supervising mental health teams?
- What do they understand the purpose of social supervision to be and what are their feelings towards it?

In the following section I aim to make a number of issues explicit to the reader. I begin by giving an overview of the ways in which mentally disordered offenders might be diverted from the criminal justice system. All research participants were all subject to section 37/41 of the Mental Health Act 1983 (as amended by the Mental Health Act 2007) (MHA) (DOH, 2007a) and I therefore pay particular attention to the workings of this section. I move on to explain my own reasons for focussing on this area and outline assumptions that I bring to the research. I end the chapter by



providing an outline of the thesis structure.

### **Routes through the mental health system for mentally disordered offenders**

There are a number of ways that an offender with a mental health problem may be diverted from the criminal justice system in England and Wales. Diversion can occur, “before arrest, after proceedings have been initiated, in place of prosecution or when a case is being considered by the courts” (Bradley, 2009, p. 16). Where a case is brought to court, a judge or magistrate has several options. They may make an offender subject to criminal sanctions. In cases where it is unclear whether a person is suffering from a mental disorder they may apply for a hospital order so that the condition may be assessed under section 35 of the MHA (DOH, 2007a). In cases where two medics are of the opinion that an offender suffers from a mental disorder, and their offence would warrant a custodial sentence in law, then a judge or magistrate may impose a hospital order under section 37 MHA. Hospital orders can be viewed as “almost wholly medical in nature” (James, 2010, p. 242) as they are not regarded in law as either a deterrent or punishment and the Secretary of State holds no power over offenders made subject to them.

In cases in which an offender is judged to have committed a serious offence, a judge may choose to impose a ‘restriction order’ under section 41 of the MHA (DOH, 2007a). This order can only be imposed in cases where it is “necessary for the protection of the public from serious harm” (section 41 (1) MHA, cited in Jones 2011, p. 250). Although a hospital order with a restriction still maintains the purpose of treatment rather than punishment (R v. Birch (1989 11 Cr.App.R.(S.) 202 cited in Jones, 2011) the same ruling states that the offender should no longer be, “regarded

simply as a patient whose interests are paramount” (p. 235). Competing notions of public protection are therefore introduced. The effect of this order is to give powers of leave, transfer and discharge to the Secretary of State. In addition, conditions are normally applied on discharge (under section 42), which give the Secretary of State the power to recall the service user in the event that they fail to comply. Guidance given to those responsible for their supervision (known as social supervisors and supervising psychiatrists) emphasises that supervision should primarily be concerned with reducing the degree of risk to the public through regular monitoring and supervision (MOJ, 2009a, 2009b). Mental health professionals dealing with mentally disordered offenders are therefore required to work within the principles of the Care Programme Approach (CPA) (Reed, 1992), as well as being tasked with predicting and minimising the risk of future offending. In cases where service users are subject to section 37/41 MHA they may be granted a discharge by either the Ministry of Justice (MOJ) or the Mental Health Review Tribunal (MHRT) under section 73 MHA. Those who are discharged are normally granted conditional discharge in the first instance. Unlike, Community Treatment Orders there are no statutory or set conditions given to those granted a Conditional Discharge. Instead, the MHA grants the secretary of state a general power of recall under section 42 (3). Except in cases of emergency, the power can only be exercised after medical evidence has been obtained.

There are limitations in the kind of conditions that the MOJ or tribunals may impose. They may not impose conditions which would amount to a deprivation of liberty, nor may they propose particular sanctions should a person subject to conditions fail to comply with them (Jones, 2011). The MOJ does have views as to which conditions it

sees as being important. In its Guidance to Clinical Supervisors the MOJ states that the Secretary of State would normally impose conditions relating to residence at a certain address and that service users should comply with social and clinical supervision (MOJ, 2009a, para 7). The MOJ also indicated that they will use their powers under section 73(4) to impose such conditions where a tribunal has failed to do so.

In some cases, those subject to social supervision may have a condition stating that they should comply with medication prescribed by the Responsible Clinician. In *R (on the application of SH) v MHRT* (cited in Jones, 2011, p. 412), Holman, J. ruled that a condition stating that the patient “shall comply” with medical treatment did not breach his rights under Article 8 (1) (right to respect for Private and Family Life) of the European Convention of Human Rights. This judgement was made on the basis that the condition should represent the patient’s final real and true choice and that a tribunal should not impose such a condition unless it believed that the patient would consent to the treatment in question. MOJ guidance to Clinical Supervisors also notes that Clinical Supervisors have no legal power to require a patient to take medication but states (MOJ, 2009a, para 31),

...where medication is prescribed to relieve mental disorder which, if untreated, would be likely to lead to the patient becoming a danger to himself or others, the patient’s co-operation with such medication is likely to be fundamental to him remaining in the community. If, therefore the patient refuses medication against the clinical supervisor’s advice, he may need to be recalled to hospital as a detained patient.

Current case law indicates that a breach of conditions is not a sufficient ground for recall in itself. Rather a breach should lead the Secretary of State to consider on the basis of medical evidence whether the statutory criteria for admission has been met.

Case law requires that medical evidence confirm a patient is suffering from a mental disorder of a nature or degree to warrant detention before a recall can be made.

However, it is not necessary for there to have been a deterioration in mental health before a recall can be made (a full summary of the case law relating to recall is given in Jones, 2011, p. 262-270).

### **The researcher and reasons for interest in the research topic**

My research aims were informed by my own experiences of working with people who were subject to section 37/41 MHA. I began my doctorate studies at Cardiff University in 2006, having at that point been a qualified social worker for eight years. At that time I was working as a Senior Practitioner in an NHS Medium Secure Unit. During my time in the unit I had become interested in the way that risk was conceptualised. On starting work at the unit I became aware that many of the patients had been detained for a number of years (which was extremely rare in general mental health settings). It also appeared that the majority of patients were less acutely unwell than many of the service users that I had been used to seeing in the community. Despite this, staff would frequently comment that they were working with the most 'risky' group. This led me to question the way in which risk was interpreted by workers. The unit was highly staffed and so the risk to hospital workers appeared to be less than that to workers in the community. I also became aware that although forensic mental health hospitals were tasked with the job of assessing and treating patients, the more difficult job of managing that risk in the community was passed on to community teams. The issue of risk therefore was somewhat different from the way in which I had come to understand it as a community worker. Patients were admitted on the basis that they were seen to pose

a serious risk to others (with those not meeting the thresholds for the service being rejected) and were discharged when they were judged to no longer pose a risk. In the case of restricted patients, decisions about acceptable levels of risk required before discharge were made by either the Ministry of Justice (MOJ) or a MHRT. Risk therefore was judged historically (in terms of the offence that the service user had committed and their behaviour on the wards since admission) and was also judged with an eye to the future (were there enough controls in place to prevent a risk of future harm)? Staff at the unit held regular meetings in which levels of risk were assessed and debated. Inevitably, staff held different views about the antecedents for risk and the measures required to prevent them. However, in my view service users were rarely asked about the way in which they conceptualised risk or how it should be controlled. Although the offence leading to the order was sometimes discussed with service users I felt that there may have been pressures for service users to interpret these events in certain ways. As Rosenthal (1973) has argued, an admission of mental illness may be a pre-requisite for discharge from psychiatric hospital. These interests led me to pose the research questions that this thesis addresses. That is, how do service users come to explain their own offending once discharged and how do they conceptualise social supervision and the process of risk management within it?

### Some assumptions

I will now outline some of the preconceptions that I brought to the research. As Delamont (1992) notes, preconceptions are not a bad thing in themselves. Rather the danger lies in such preconceptions remaining “implicit, unacknowledged, and unexamined” (p. 77). As this thesis deals with offenders who are judged to be

‘mentally disordered’ it is important to outline my own views toward mental disorder / illness. Attitudes towards mental illness might usefully be viewed as a continuum. On the one hand are those authors adopting what Double (2002) refers to as a neo-Kraepelinian approach <sup>1</sup> who believe that a boundary exists between ‘normal’ and ‘sick’ people and who view mental disorder as being biological in nature. On the other hand would be authors such as Szasz (1974) who argue that mental illness is not objectively visible and is a pseudo-science. According to such views, the real purpose of psychiatry is to define and contain unacceptable social behaviours. Labelling theorists such as Scheff (1966, 1974) come from a similar perspective arguing that labelling is strongly influenced by the social characteristics of both the person being labelled and the labeller. Furthermore, Scheff argues that once a label has been given, powerful social forces come into place to maintain it. My own position would be to accept that mental illness does exist and has a negative effect on the lives of those who suffer from it. I do accept that definitions of mental illness are constructed within a social context and that psychiatric diagnosis involves a degree of subjective judgement. However, I do not feel that these shortcomings negate the need for a system of classification. I do believe that labelling has an effect, but I hold a position closer to Link’s modified labelling theory (Link *et al.*, 1989; Link and Phelan, 2010), which highlights the way in which stigma may damage individuals’ life chances rather than claiming that labelling causes mental illness.

Having trained as an Approved Mental Health Professional I have been schooled in the importance promoting an individual’s legal rights. At the outset of this research it would have been my view that conditions of discharge acted mainly as mechanisms

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<sup>1</sup> Emil Kraepelin is often identified as the founder of modern scientific psychiatry.

of social control through restrictions imposed on service users. My initial belief was that research participants would focus primarily on the restrictive outcomes of risk assessments, although this turned out not to be the case. The research process has therefore changed my views as to the appropriate use of risk assessments and I outline my final thoughts in my conclusion.

### **The structure of the thesis**

Having outlined the legal basis for the order and my own suppositions, I move on to review the current literature in Chapter Two. My literature review begins by outlining theoretical perspectives on risk relevant to the research topic. This chapter also provides a review of qualitative research into service user and staff perceptions of forensic mental health care and risk. In Chapter Three I set out my main research questions and outline my methodology. I begin to outline the findings of my research in Chapter Four. This chapter sets out the way that service users sought to dignify and explain their offending behaviour. Chapter Five focusses on service users' awareness of risk assessment and management plans that had been written about them by professional staff. The chapter also examines service users' awareness of their conditions of discharge. The sixth chapter explores service user perspectives on the supervision process itself, examining their views toward the processes of control inherent within this process. I conclude in Chapter Seven by examining some of the theoretical ideas presented in the thesis as a whole before considering how my findings add to the existing body of research. I go on to suggest areas for future research. Finally, I consider the implications for social work practice focussing on the ways in which social workers might seek to manage ethical dilemmas presented by this area of work.

There are also a number of stylistic points which should be drawn to the reader's attention. Extracts from interviews with participants have been punctuated to aid comprehension. Pseudonyms have been used for service users, staff and place names. On occasion I have added explanations in square brackets (for example, indicating that a service user is referring to a high secure hospital). I have used '...' to indicate instances where a section of a quote has been removed. Debate exists as to whether the group of people that I am researching should be referred to as patients, service users or clients. Recent research has indicated that the term 'patient' was the most popular label amongst those detained in low and medium secure settings (Dickens *et al.*, 2011). However, I have used the term 'service user' in this thesis. This is because the term 'patient' has traditionally framed individuals as being the focus of medical care. A number of participants in this study have objected to this. I have therefore used the term service user as this enables a more fluid discussion of these tensions.



## **Chapter Two - Literature Review**

### **Introduction**

This chapter will provide an overview of the literature which deals with various perspectives on risk in relation to mentally disordered offenders. There is an extensive literature on the sociology of risk. This chapter therefore begins with an outline of Beck (1992) and Giddens' (1998) risk society thesis. I then go on to discuss theories of identity, governmentality and social control as a means to understand the way in which service users may understand both their own risk and processes taken by others to control their level of risk. The chapter then moves on to focus on the way in which theories of risk might be applied to welfare with a particular focus on forensic mental health policy. In order to focus on the way that risk is experienced by various actors within the mental health field, the professional perspectives of risk will then be outlined followed by those of service users. The decision to order the material in this way is not designed to suggest that greater weight ought to be given to the views of professionals. Qualitative research into forensic mental health remains limited (Coffey 2006). Of that research, there is a greater emphasis on professional notions of risk than on those of service users. Research into service users' views indicates that they often feel that they need to acquiesce to professional views in order to achieve discharge (Coffey 2011; Heyman *et al.*, 2004). This view arises from awareness that professionals have various powers over service users within a hospital setting and have the power to recall service users once they have achieved discharge. This indicates that service users' views are often formed with reference to professional views, hence the decision to order the material in this way. The review of the literature related to professional and service user perspectives on risk will be formatted in a way that

mirrors the processes that service users are subject to with each of these sections exploring risk issues at the point of admission to hospital through to discharge and community supervision. The chapter ends by outlining the gaps in current knowledge which have led to the research questions and goes on to outline the theoretical assumptions which might be tested by this work. The search strategies adopted in this review are outlined in Appendix 10. The chapter now begins by outlining the sociological perspectives on risk.

### **Sociological approaches to risk**

The term 'risk' has become increasingly used by a wide variety of disciplines. This has led to a number of theoretical conceptualisations. This section begins by outlining some general assumptions shared by all theorists. Post-renaissance views of risk are based on the assumption that there are universal laws and causality (in contrast to pre-renaissance notions of fate) (Kemshall, 2002). Risk thinking is therefore linked to predictions or expectations that an action may lead to a specific outcome. This may be understood as both a formal process (in which statistical methods are used) or as a less structured process; although each process will be influenced by socio-cultural and individual perceptions (Zinn, 2008).

This thesis is concerned to examine risk from a sociological perspective and the following section gives an overview of the main theories used. The 1990s saw the growth of risk thinking in late-modern western society. During this time, notions of risk management that had originated in insurance and engineering became increasingly applied to other spheres of activity such as social work, criminal justice and mental health (Horlick-Jones, 2003). Risk has been understood in different

ways by different social scientists. The most influential from a Western perspective are Beck's (1992) risk society thesis and Douglas' (1992) cultural approach. In addition to this, governmentality theories have focussed on the way that risk is identified and treated. Governmentality is not strictly a risk theory and was developed by Foucault to chart historical changes in Governance in Europe although it has since been developed by writers such as Rose (1996; 1999; 2000), Castel (1991) and Dean (2010) to deal specifically with notions of risk and risk management.

In addition to the theories above, I draw on a number of others in order to understand service user understanding of the way in which strategies for managing risk are applied. In Chapter Four, I have drawn on notions of symbolic interactionism (Blumer, 1962; Goffman 1990a; Goffman, 1990b; Mead, 1997). Whilst symbolic interactionism would not ordinarily be understood as a risk theory, I have used it to make sense of what Horlick-Jones refers to as the, "informal aspects of the regulatory process" (2005, p. 304), that is, the processes used by individuals to manage their own risk within more explicit risk management frameworks. In Chapter Five, I examine research participants' awareness of risk assessment and management plans and their conditions of discharge. Theories of governmentality are used here to examine how far participants may be seen to be managing their own risks. In Chapter Six I draw on theories of social control to understand the way in which users understand responses to risk management measures imposed by the Ministry of Justice and mental health professionals. Although I have not focussed heavily on Beck (1992) and Giddens' (1998) theories within this thesis, these theories are often used in the literature to explain the growth in risk related practices

in health and welfare. I will therefore briefly outline the risk society thesis before moving on to discuss theories that are more central to my argument.

### **Beck's theory of risk society**

Beck (1992) has argued that the concept of risk has become a key organising principle within western societies. He constructs a grand theory which outlines how the concept has become pivotal to late-modern thinking. Beck argues that governments, institutions and individuals have become pre-occupied with the notion of risk. This does not indicate that the world has become a more hazardous place but rather that society has become increasingly occupied with the future and with notions of safety (Giddens, 1998). As a result of this, governments have become concerned with the prediction and minimisation of risk.

Beck's (1992) theory of risk society is based on a number of precepts. Firstly, the institutions that were previously seen as controlling risks are no longer viewed as having retained this control. This is because the types of risks that society produces have changed. His arguments here are primarily based on the relationship of individuals to nature. He argues that industries now have the capacity to create risks that will have repercussions worldwide (Beck distinguishes 'risk' from 'dangers' which are seen as occurring naturally). In addition to this, the public perception of risk has changed. Whilst risk was previously viewed as hazards from nature, for example, floods and famine, the public has come to realise that the processes of modernisation may themselves create risks such as acid rain or problems arising through the genetic modification of nature. This process has created distrust in experts. However, a central paradox to the theory is that whilst this distrust exists,

there is also a parallel demand for risks to be minimised and controlled. These theories can be seen to relate to issues of trust between mental health professionals and the public. Recent policy has been pre-occupied by the risk that those with a mental health problem are seen to pose to others. This call for greater risk management can be seen to relate to a failure of trust; that is cases where mental health professionals are judged to have failed to assess risk accurately (Brown *et al.*, 2009; Pilgrim, 2007). However, despite this lack of trust in experts Governments may call for mental health professionals to do more to identify and manage risk more effectively, introducing more co-ercive forms of treatment in order to encourage this (Vassilev and Pilgrim, 2007).

Although the above risk theories explain the way in which risk is perceived at a societal level, they are less useful at explaining the way in which individuals may account for their actions. Horlick-Jones (2003) suggests that whilst Beck and Giddens are concerned with the distribution of 'bads' within society, risk theorists also need to map the way in which individuals interact with risk practices. Drawing on previous risk studies he argues that individuals feel a need to account for, "risk-related actions in ways that not only make sense, but also present those actors in a 'good' or morally acceptable light" (2003, p. 226). The following section provides some of the theoretical perspectives which will be used to explore the ways in which research participants justified their actions. I begin by considering theories of identity and how these relate to mental disorder.

## **Identity and mental disorder**

Notions of identity are a concern to a wide variety of academics including sociologists, psychologists, feminists and psychotherapists. Social interactionist perspectives on identity reject an essentialist position in which identity is seen as discreet and embedded within individuals (Ransome 2010). These perspectives are seen as being founded by Mead (1997), who saw the self as being divided into two halves which he referred to as the 'I' and the 'me'. The 'I' is regarded as the inner subjective self which constitutes an individual's wants and wishes. The 'me' is viewed as the outer identity which was concerned with perceptions of how others view us. Knowledge of who we are is therefore seen to be dependent on social interactions through which the self is adapted. Drawing on Mead's social interactionism, symbolic interactionists placed emphasis on the way in which social interactions are constructed. Social identities are seen as being based on symbolic exchanges (for example, language as a form of meaning-making) in which individuals give significance to one another's actions through interpretation (Blumer 1962). Understandings of the self are therefore 'collaboratively manufactured' (Goffman 1990a).

Mentally disordered offenders will seek to develop and negotiate their own identities, but will have to do this within their status as people who have been identified by the legal and medical system as being both mentally disordered and offenders. From a symbolic-interactionist perspective these particular identities may be defined as 'stigmatised' or 'deviant' in that they reflect attributes that are viewed as deeply discrediting by society (Goffman, 1990b). From this perspective, deviance is not seen as denoting a quality in itself, but is seen as a social label which takes effect

when it is successfully applied by others (Becker, 1991). Crime and illness may both be designated as deviant forms of behaviour that attract a level of stigma. However, the social responses to crime and illness may be different. Conrad and Schneider argue that,

Criminals are punished with the goal of altering their behaviour in the direction of conventionality; sick people are treated with the goal of altering the conditions that prevent their conventionality (1992, p.32).

Thus, whilst a diagnosis of medical illness may be viewed as stigmatising, it has different consequences from a label of deviancy without mental disorder. Different weight may be given to each of these identities by either the individuals themselves or the professionals around them.

When considering how mentally disordered offenders account for action it is therefore important to consider how they might characterise both their illness and their offending. Labelling theorists (Scheff 1974; Rosenhan 1973) have tended to focus on the effect that being labelled has on an individual or group in relation to notions of social control which will be outlined later in this chapter. Both individuals and groups may resist such labels and I discuss resistance toward medical labels in more detail in Chapter Six. At this point, I would note that individuals may react to a diagnosis of mental illness in a range of different ways. One way in which they may explain this is by reference to the social difficulties that they experience as a result of this labelling (Roe, 1999). This may lead such individuals to speak of a desire to be 'ordinary' (Coffey 2011; Roe, 1999; Wisdom *et al.*, 2008). However, it would be wrong to argue that individuals given a diagnosis of mental illness always view these issues in societal terms. Rather, individuals may focus on the threat that illness poses to them as an individual. Within these explanations illness may be seen as a

separate entity threatening the healthy self. Qualitative research by Wisdom *et al.* (2008) and Roe (1999) indicates that many service users convey an essentialist form of self in which the 'real me' may be seen to be under threat. Alternatively, some service users with mental health problems have spoken of having dual selves and differentiate between 'myself' and 'myself when I am ill', whilst in other accounts, notions of self and illness are integrated.

Mentally disordered offenders differ from the majority of mental health patients in that they also have to manage their identity as offenders. Qualitative research into offender accounts indicates that individuals are concerned to present themselves as moral (Presser 2004; Geiger and Fischer, 2005). They may therefore choose to resist or to minimise the effect of their offending identities. Offenders may resist negative labels through using what Sykes and Matza (1957, p. 668) refer to as 'techniques of neutralisation'. These authors argue that offenders adopt a number of techniques in order to provide rationalisations for deviant behaviour. These rationalisations allow individuals to 'drift' in and out of sub-cultural identities. Consequently they are able to engage in offending without accepting a deviant identity. Such rationalisations may precede offending and act as a continuing justification for acting outside of society's norms. Offenders may also resist negative attributions by others through emphasising human strengths, such as courage, perseverance or honesty (Geiger and Fischer, 2005). Where resistance does exist, the forms that this takes may be complex. As Crewe (2007) notes, although individuals may seek to resist the values imposed by the justice system, they may still use the language of this system as part of the process of resistance. The issue for those who have been identified as both mentally disordered and as offenders is



how both of these attributions are managed. Consideration needs to be given as to whether both of these labels are resisted or whether one is given prominence over another. This issue will be explored in Chapter Four.

## **Governmentality**

Foucault's (1991) theory of governmentality provides a useful means through which to analyse the extent to which individuals are aware of and use risk assessments. Foucault's theory refines his earlier theories of power / knowledge and forms part of a historical analysis into the ways in which governmental control developed in Europe. Foucault was concerned with the way in which governmental power was developed within western societies. He charted a move away from sovereign power in which the mass populations were terrified into compliance through public displays of punishment towards new forms of governance in which monitoring and protection were achieved through, "the ensemble formed by institutions, procedures, analyses...reflections, calculations and tactics" (1991, p. 102). In other words, a shift occurred from a system in which sovereign power was exercised in a top down fashion to one in which power operated at both organisational and individual levels. Whilst this may not lead to state agencies transferring all their powers to others, an increasingly diverse range of agencies become 'responsibilised' into identifying and minimizing risks such as crime (Garland, 1996). Rose (1999) argues such systems have led to an increased emphasis on the need for individuals to exercise power in their own lives. Consequently individuals are not only encouraged but are compelled to manage their own risk, with those who are unwilling or unable to do so becoming the focus of professional services tasked with reducing risk (Rose, 1999). Castel (1991) argues that psychiatry provides an example of governmentality in that it

developed as an organisational site of power through developing particular types of social control. He argues that a change occurred from one in which professionals saw danger as residing within specific individuals towards one in which risk was viewed and monitored primarily at a population level. Castel contends that this led to the development of an 'epidemiological clinic' in which professionals aimed to control and diminish risk through an increased focus on records and forms of control aimed at the general population. As with Beck's (1992) theory, risk rather than need is seen to be the driving force through which services are organised.

There are a number of criticisms that have been made against governmentality theory which are relevant here. The theory tends to deal with the distribution of power at an abstract level and has both been criticised for giving an undeveloped account of human agency (Lupton, 1999) and for viewing individuals as easily manipulable by experts (Taylor Gooby and Zinn, 2006). Consequently the theory may neglect the way in which processes of governance are resisted. These issues will be discussed in Chapter Five, which considers whether risk assessments and conditions lead to mentally disordered offenders taking responsibility for their own risks in the way envisaged by governmentality theorists.

## **Social control**

Theories of social control have been used to understand how the actions of individuals are regulated by a wide range of social agents across a range of settings. These theories have been used differently by symbolic interactionists, functionalists, Marxists and post-structuralists in order to understand the way in which social order is defined and maintained (Innes, 2003). These explanations have a broad span,

focussing on both formal responses to deviance (such as policing) and on the ways in which individuals are conditioned into accepting particular values (through processes such as schooling). Cohen has been critical of the breadth of social order theories falling under this label and has argued that this has led to social control becoming a 'Mickey Mouse concept'. He proposes a narrower definition of social control which focusses on,

...those organised responses to crime, delinquency and allied forms of deviant and / or socially problematic behaviour which are actually conceived of as such, whether in the reactive sense (after the putative act has taken place or the actor been identified) or in the proactive sense (to prevent the act)... (2005, p.3)

This thesis focusses on mental health service users who are subject to this narrow definition. However, in explaining how they experienced control, research participants often referred to informal processes (such as peer pressure) as well as more formal processes (such as supervision). In order that both these elements can be examined I begin by outlining Parsons' theory of the sick role. I then move on to discuss the social control of mental illness before looking at arguments relating to social control and individual agency within the social work literature.

Sociologists of health and illness have been interested in notions of social control since Parsons (1951; 1975) developed his functionalist perspective of the 'sick role'. Parsons theory is significant because he focussed on both the institutional expectations and sanctions toward sickness. He argued that the 'sick role' exempted the individual from everyday tasks but that this needed to be legitimated by an authority such as a medic. This exemption is seen to be conditional upon the individual attempting to recover through accessing technically competent help. Thus, doctors and health professionals are seen to exercise control through defining

the limits of individual responsibility. Parsons argued that the process of social control is reliant on individuals accepting their role as patients as well as the assumption that health is desirable and sickness is to be avoided. This relationship is seen to maintain social control, although Parsons says relatively little about the management of cases in which patients may resist the role.

Early attempts to explain the way in which mental illness has been defined and controlled came from labelling theorists whose ideas have been outlined in the identity section above. Scheff (1966; 1974) argued that labelling is a process of control which occurs both through the imposition of a label by authority figures and by a process of 'secondary deviance' in which an individual conforms to that given identity. Thus, in the instance of mental health a patient may be given a diagnosis of schizophrenia and then enact the behaviour expected of a schizophrenic in order to gain reward from the system (such as discharge from hospital). This view of control was originally supported by Rosenhan (1973) who conducted an experiment in which he and a number of research assistants reported false symptoms which resulted in their hospitalisation. Rosenhan's experiment has become notorious because he and his assistants had trouble achieving discharge, despite not displaying any subsequent symptoms. Rosenhan has noted that, "the only way out [of psychiatric hospital] was to point out that they were correct. They had said I was insane, I am insane, but I'm getting better. That was an affirmation of their view of me" (quoted in 'The Trap: What happened to our dream of freedom', 2007). Scheff's theory has been questioned on a number of grounds. Drawing on accounts from both medics (Spitzer and Williams, 1982) and users of services (Anonymous, 1982), Gove (1982) has argued that those with a label of mental illness were given such labels as a

consequence of impairment and that labelling theorists tend to minimise the disorder and its severity. Thus from a social control perspective we might wonder how far individuals are complying with the labels given to them because of societal pressure or how far they are engaging with them due to their own sense of personal agency.

The dilemma about the degree of agency that those with a diagnosis of mental illness may have is echoed in the literature about social work and social control. Recent debate in social work literature has focussed on how far individuals who have contact with social services are subject to social control and how far they choose to engage with services as a process of self-development. Much of this argument focuses on Giddens' and Beck's theories of individualisation which have been applied to social work by Ferguson (2001). As these arguments have not yet been applied to mental health within the social work literature I will draw on examples from child protection here. Giddens (1992) argues that individuals have increasingly been encouraged to develop their lives away from modernist norms. The self is seen as a reflexive project in which the question of "who shall I be?" is tied up with "how shall I live?" (p. 198). Ferguson (2001) argues that social workers are involved with "life planning" in that they assist individuals to resolve the choices and problems that they face. Ferguson (2001) argues that this process of 'individualisation' is linked to individuals' increased awareness of risk. Risk attitudes are only seen to make sense in cases where outcomes are seen to be dependent on social agency rather than being fixed, although an increasing amount of social decisions have moved from being regarded as inevitable to the sphere of personal responsibility. Ferguson cites his own research (Ferguson and O' Reilly, 2001) into mothers' interaction with child protection services to argue that individuals are able to make informed choices

when engaging with services. In doing so they were able to balance the risks between staying in a violent relationship against the risk of having their children taken into care. Ferguson is critical of radical social work authors who he argues have focussed on risk primarily as a means of regulation. He argues that this neglects the way in which social work may be used to help service users form a 'well protected self' (p. 48) which considers risk in a dynamic and reflective way. This position has been criticised by Garrett (2003; 2004) on the grounds that Ferguson's theory draws on Giddens and Beck which Garrett argues underplay the restraining influences of social structure and material inequalities. This echoes wider criticism of Giddens' structuration theory (1970) which posit that in aiming to theorise how individuals change social rules he unhelpfully conflates notions of agency and structure (Archer, 1982). Scourfield and Welsh (2003) also criticise Ferguson's perspective on the grounds that he underplays the extent of social control. They use earlier research by Scourfield (2003) to illustrate the ways in which social workers use their authority to encourage compliance with parenting plans. For example, one worker states, "I spell it out . . . if we don't do ABC we'll be going back to court. If things don't change there'll be consequences . . . spelling it out – this is the situation" (p. 410).

Scourfield and Welsh (2003) argue that whilst service users may be presented with choices, these choices are narrowly defined and are experienced as social control. Whilst no research has investigated individualisation within the mental health field, parallels can be drawn with the ways in which mental health professionals use their power in relation to service users subject to section 41 MHA. Service user

perspectives on the way in which restriction orders are used and the degree to which these are seen as a means of social control will be explored further in Chapter Six.

### **Risk issues within forensic mental health policy**

In order to examine the way in which concepts of risk affect mentally disordered offenders I will begin by outlining arguments about the way that notions of risk affect the provision of welfare generally. I will then move on to focus on general mental health policy before outlining law and policy that applies specifically to those subject to section 37/41 MHA.

Notions of risk can be seen to relate to the provision of welfare in a number of ways. Kemshall (2002) provides a useful overview of the way in which the application of risk concepts have changed within welfare services in the UK. She argues that traditional welfarism focussed on both needs and risks with the concept of risk being inherent in Beveridge's notion of a workforce insurance system. Within this system, risks were seen to be located outside of the individual. She argues that the Thatcher Government radically altered the way that welfare services were organised moving to a more individualised approach to risk. This was most clearly seen in the effect of the NHS and Community Care Act 1990 (DOH, 1990b) which altered the role of social workers from providers to purchasers. Kemshall argues that whilst the Community Care Act 1990 instructed social workers to assess need, contradictory expectations were issued by Government for local authorities to focus on "only the most needy" (p.77). This created a system in which notions of risk and vulnerability were used to ration limited resources. From a governmentality perspective, Rose (1996; 1999; 2000) argues that restrictions in state expenditure need to be seen

against a trend for neo-liberal governments to encourage prudentialism in their subjects. Within this system free choice has become an obligation (Rose, 1999). Social work intervention therefore becomes focussed on, "...those who are unable or unwilling to enterprise their lives or manage their risk, incapable of exercising responsible self-government" (2000, p.333). Webb (2006) builds on Rose's ideas to argue that social work has become concerned with privatised risk in which those who are incapable of self-management become subject to expert mediation. He paints a pessimistic picture of such developments and argues that such 'technologies of care' lead practitioners to become concerned with providing audit trails of risk assessments rather than engaging on a face to face basis with individuals. This view holds parallels with Castel's (1991) 'epidemiological clinic' in which risk assessments are used within psychiatry as a means to identify 'at risk' groups from a distance. However, as Godin (2006, drawing on Dean, 1997) notes,, the 'epidemiological clinic' does not signal an end to face-to face practice. Rather, mental health services are focussed on those who are perceived to pose the highest risks. In order to examine the way in which risk is identified and regulated I turn next to responses toward risk within mental health policy.

Mental health policy in the UK directs organisations and to a lesser extent individuals to manage risk in certain ways. Government guidance to health and social care services were first introduced in 1994 (NHS Executive, 1994) in response to high profile cases involving service users. The most notable of these was the case of Christopher Clunis; a young black man who had been diagnosed as suffering from schizophrenia. Clunis had been seen by several health authorities before fatally stabbing Jonathan Zito, who was unknown to him, in a tube station in December



1992. Two weeks after this Ben Silcock, who was also a mental health service user climbed into a lion's enclosure at London zoo and was badly mauled. A film of the latter event was widely publicised in the media which led to a call for an immediate review of mental health law by the Health Secretary (Atkinson, 1996). Government guidance (NHS Executive, 1994) issued in response to these incidents emphasised that risk assessments should be carried out before discharge and should take place within the Care Programme Approach (CPA) (DOH, 1990a) which had been designed to provide a co-ordinated response between health authorities and social services departments. Subsequent guidance advised that an assessment of risk should form part of all mental health assessments (DOH, 1995). The incoming New Labour Government extended this further through advising that all mental health staff involved in the assessment of service users be trained in risk assessment and management techniques (DOH, 1999).

Recent Government guidance (DOH, 2007b) addresses the way in which both organisations and individuals should manage risk. It envisages that professionals will take the lead in risk assessments but that such assessments will assist individuals to act responsibly. The Department of Health are critical of professionals using either an unstructured clinical approach or an actuarial approach alone. Unstructured clinical approaches are characterised as being anecdotal and inconsistent with risk information not being recorded in a standardised way. In contrast, actuarial assessments are seen here as being formulaic with clinicians focussing on static risk factors (such as age, gender or history of previous violence) in order to calculate an indicator of future risk. The guidance advocates the use of a structured clinical approach, in which decision making is informed by actuarial

assessments but is mediated by professional judgement. In line with previous reports it emphasises the need for assessments to be collaborative and based on principles of recovery (DOH, 2007b; DOH, 2004; NICE, 2006), implying a stakeholder model (Rush, 2004) in which the views of service users are heard but in which inequalities in power are accepted. Hence, professionals are advised to consider coercive action under the MHA in cases where service users are judged to pose a risk to themselves or others as a result of mental disorder.

Whilst there has been an increased emphasis on risk within general mental health services since the 1990s, the identification and treatment of dangerous behaviour has been a concern of forensic mental health services since their inception.

Separate forensic services were established in the UK through the 1860 Act for the Better Provision and Care of Criminal Lunatics (Forshaw, 2008). Whilst the 1959 MHA provided the basis for care in the community for those within large hospitals or asylums, this trend did not initially extend towards mentally disordered offenders (Jewesbury and McCulloch, 2002) , although selected service users were discharged from secure care in the 1960s (Prins, 1999). The need for a stepped approach toward discharge was highlighted by the Butler Report (DOHSS, 1975) , leading to the creation of Regional Secure Units (now more commonly known as Medium Secure Units) which were to provide a lower level of security than the existing high secure hospitals. The Reed Report (1992) went on to place forensic mental health services within the context of the CPA framework and can be seen to be a re-statement of the principles of community care (Jewesbury and McCulloch, 2002) highlighting that mentally disordered offenders should be treated in the community

where possible and that they should not be treated in levels of security not justified by their danger.

## **Professionals' and service users' views on risk**

Having outlined a number of theoretical perspectives on risk I will now move on to focus more specifically on how notions of risk are interpreted by professionals and service users within forensic mental health settings. Previous risk research has found that whilst formal risk management practices may be seen to be increasing, the way in which individuals interact with them is complex. Whilst individuals may be encouraged or compelled to follow risk management procedures these are rarely applied in their pure form and individuals may also be guided by informal logics of risk management (Horlick-Jones, 2003; Broadhurst *et al.*, 2010; Kemshall, 2010). In considering the way in which individuals understand risk I have therefore focussed on their understanding of both formal and informal processes as well as examining the different ways in which they conceptualise risk. I will begin by outlining the views of mental health professionals before moving on to consider service users' views of risk.

### **Professionals' views**

#### **Admissions procedures and risk**

I will begin my section on professional views of risk with a discussion of the way that risk is considered by different parties when a decision is being made as to whether to admit someone under section 37/41 MHA. The decision as to whether to make an application is made by a judge on the basis of medical evidence. As stated earlier, the order is imposed in cases where the service user is viewed to be a significant

risk to the public. However, the weight which should be afforded to public protection is not made clear in the MHA and the revised Code of Practice (DOH, 2008) also offers no guidance on this matter. As a result of this, the way in which judges and medics interpret these concepts becomes important in defining who is made subject to such an order.

Research by Humphreys *et al.* (1998) examined the practice of consultant forensic psychiatrists in making recommendations to the court. Whilst the statutory guidance to clinicians to consider the “nature of the offence” was open to interpretation, the authors noted that a large percentage of participants cited reasons outside the statutory criteria when recommending an order. Amongst these participants the notion of risk to others was seen to emerge from a relapse in mental illness. The ability to enforce pharmacological treatment was seen as an effective means to prevent this. However, whilst medics made recommendations to the court, the decision as to whether to impose a restriction order is made by a judge.

Research by Qurashi and Shaw (2008) highlights tensions between medical and legal perspectives during the trial process with the majority of judges indicating that public protection was their only consideration when making an order. In making an assessment of risk, judges unsurprisingly paid attention to the statutory criteria set out in section 41(1) of the MHA which relates to the nature and antecedents of the offence. However, they also considered the seriousness of the offence and any actual or potential violence inflicted. Whilst compliance with medical treatment was seen as a potential benefit of a restriction order, this was viewed as a secondary benefit and psychiatrists were sometimes criticised for focussing on issues of treatability rather than risk to others.

### *Differing professional views in secure hospital settings*

Service users who are detained under section 37/41 MHA are treated within secure psychiatric hospitals before becoming eligible for conditional discharge. It is therefore important to assess the way that risk is understood by different parties within these environments.

Care in forensic hospitals is delivered by multi-disciplinary professionals. As Luhmann (1995) notes, professional groups may be constrained by their own identities and regulatory structures and research within forensic settings supports the view that professional identity affects the way that risk is conceptualised. Medics were widely viewed as the most powerful group within studies by Davies *et al.* (2008), Davies *et al.* (2006) and Godin *et al.* (2006). Medics tended to view risk as emanating from mental illness (Davies *et al.*, 2006; Godin *et al.*, 2006; Grounds *et al.*, 2004). For example, forensic psychiatrists in Davies *et al.*'s study (2006) put forward the view that a forensic hospitals should make the pharmacological treatment of patients their priority and that this in turn would reduce risk. However, some medics have been more circumspect with a participant in Grounds *et al.*'s (2004) study stating that whilst it might be possible to treat an individual's mental disorder there was no way to exercise control over a person's personality, life choices or social circumstances. Nursing staff and health care assistants within Davies *et al.*'s (2006) study tended to be critical towards what they viewed as a medical emphasis on drug treatments as a means to reducing risk. They saw risk as arising from both criminogenic factors and mental disorder. However, their ability to act on these assumptions was limited. In reference to the same research project, Godin *et al.* (2006) noted that nurses and nursing assistants tended to be more

restricted than other groups by agency risk protocols which sometimes required them to act in a manner that they found counter-intuitive. The way in which forensic social workers and psychologists theorised risk was less clear in the literature. Social workers in Davies *et al.*'s (2006) study were amongst those giving consideration to the ecological effect of the unit. This was illustrated by a social worker in the study drawing attention to a service user who had not been able to comply with the organisational regime. This was seen to lead to rebellion which led him to become further enmeshed in the system.

#### *Organisational issues in forensic hospitals*

At an organisational level, both general and forensic mental health services stratify service users according to their risk, although forensic hospitals differ in that they include sub-systems providing higher levels of security (Kennedy, 2002). Although staff in forensic mental health units hold a number of views as to the most effective way to reduce risk, organisational factors also impact on the way in which risk is managed. Heyman *et al.* (2004) argue that the function of medium and low secure units is to provide an environment where service users are enabled to make the transition from total confinement to gradually increasing levels of freedom. They liken this process to a "risk escalator" which is "orientated towards managing a defined health risk, and which is made up of sub-systems...through which service users may move" (p. 310). Whilst this is presented by managers as an ideal model, the majority of staff who were interviewed in this study found the model to be problematic in practice. Bed pressures, funding shortages and the requirement to manage a diverse patient population together disrupted the movement of service user between levels of security. Staff faced dilemmas as to how risks might be

safely tested. Whilst secure environments allowed for the containment of risk that same environment differed substantially from community settings and it therefore became difficult to predict levels of service user safety prior to the granting of community leave (Davies *et al*, 2008), which is itself subject to MOJ sanction.

#### *Ministry of Justice influence on leave decisions*

In cases where a service user is made subject to section 37/41 MHA, the Secretary of State holds power over leave and discharge decisions (although the majority of decisions are made by staff at the MOJ's Mental Health Unit). Boyd-Caine's (2010) research reveals that when making such decisions the most important factor in the minds of Unit staff was public protection. Workers at the unit were mindful of their duties to protect the public from 'serious harm' and to protect the public from 'justifiable risk'. As these terms had no definition in law or policy they required a degree of interpretation from Unit staff. Consequently, the defensibility of decisions in the event of public scrutiny was a major consideration by MOJ staff which would sometimes lead to friction with mental health professionals. For example, one MOJ staff member noted that leaves had to be justified with a therapeutic purpose, "even if the purpose is made up" (p.59). Thus leave for the sake of pleasure was seen to contradict the unit's goal of public protection and could not be considered. This emphasis on public protection was used as a means through which other professional views were filtered although this process appeared at times to be somewhat defensive and superficial. This focus was maintained as long as the service user remained subject to restrictions.

### *Social supervisors' and supervising psychiatrists' views toward supervision in the community*

Once service users are granted a conditional discharge they will receive supervision from a social supervisor and supervising psychiatrist. Both sets of supervisors monitor service users and provide regular reports to the MOJ. A number of qualitative studies have explored the views of social supervisors and supervising psychiatrists toward supervision (Coffey, 2012a, 2012b; Riordan *et al.*, 2006; Riordan *et al.*, 2002; Dell and Grounds, 1995). Amongst social supervisors, the restrictions imposed were seen to control and minimise the likelihood of future risk. Although a small amount of social supervisors felt that the supervision order was incompatible with social work values of empowerment (Riordan, 2006), it was more common for supervisors to hold a strong bias towards public protection (Coffey 2012b, Dell and Grounds, 1995). Social supervisors were aware that service users found supervision intrusive and felt that it hindered effective integration (Coffey, 2012b). Whilst some supervisors expressed a degree of sympathy for this view, it remained their view that the order remained the most effective way of minimising future risks.

Medics largely valued the imposition of a restriction order because it was seen to compel service users to take psychiatric medication and to maintain contact with community mental health teams (Riordan *et al.*, 2002; Dell and Grounds, 1995). The rationale for this compulsion was that it was viewed as a preventative measure to reduce risk to others. However, some psychiatrists expressed disquiet about the ethics of continuing to enforce treatment after a period of stability (Dell and Grounds). In addition to this, the order was viewed to be inflexible (Boyd-Caine, 2010; Riordan *et al.*, 2002) with the MOJ being unwilling to discharge service users



who the participants felt gained no benefit from the order. Supervising psychiatrists were also critical of the way in which the MOJ chose to recall service users (Dell and Grounds). Recalls were perceived to be carried out with little consultation with mental health teams and to be overly bureaucratic, resulting in long periods of detention for service users that were deemed to be unnecessary by participants.

#### *Recall decisions by the Ministry of Justice*

Social supervisors and supervising psychiatrists are required to provide regular reports which chart service user progress and levels of risk in the community. The way in which the MOJ evaluates such information is not always transparent to mental health professionals. Psychiatrists in Dell and Grounds (1995) research commented on a lack of feedback from the Unit. Research by Boyd-Caine (2010) into the practices of the MOJ Mental Health Unit found that whilst the unit liaised closely with mental health professionals, the decision as to whether to recall a service user was made entirely by the unit, irrespective of whether this accorded with the wishes of mental health staff. MOJ decisions were based on concerns as to whether “the public *might* be exposed to risk in the event of a potential deterioration” (p. 65). Thus the unit’s mandate for public protection tended to over-ride other concerns. This did not mean that all breach of conditions would automatically lead to a recall. Rather, breaches of conditions which were seen to affect a patient’s mental disorder, which in turn might constitute a risk to others, were viewed as a matter of concern.

### *Sharing risk assessments*

There is currently no research dealing with the way in which risk information is shared with service users in forensic settings. However, research by Langan and Lindow (2004) has highlighted professional views about sharing risk assessments with those under civil sections. Of the professionals interviewed, most felt that risk assessments were a common occurrence within mental health services but acknowledged that these were generally carried out without the awareness of the service users involved. The research highlighted a gap between the beliefs and practice of mental health practitioners. Whilst the majority voiced an opinion that sharing their perceptions about risk with service users was the ideal few did so in practice. The factors which prevented professionals sharing their views about risk with service users were complex but included concerns about damaging their relationship with the service user, concern about potential harm to the service user and concern for their own personal safety. In addition to this, the extent to which the service user was felt to agree with professional conceptions of risk altered how much would be shared. Professionals also demonstrated varying degrees of confidence in broaching the subject with service users which seemed to discourage such openness.

### *Summary of staff views of risk*

Research into forensic mental health professional views shows considerable difference in the way that risk is interpreted amongst professional groups. Whilst judges and medics both draw on statutory criteria when considering whether a restriction order is warranted different emphases are given to public protection and treatment compliance by each party. Once service users are admitted to forensic

hospitals they are frequently referred to in terms of their risk. However, research indicates that a wide range of perspectives co-exist with factors such as professional power and personal credibility coming to influence which views hold dominance. Environmental factors such as hospital resources have further implications for the way in which such risks are managed. On discharge, both social supervisors and supervising psychiatrists are required to monitor risk and report this to the MOJ. Social supervisors and psychiatrists saw the order as an effective means of reducing risk, although risk was conceived somewhat differently by each party. It is unclear from the current literature how far forensic practitioners share their views about risks with service users, although research within general mental health settings found that risk assessments were rarely shared.

### **Service users' views of risk**

Whilst a substantial literature on risk assessment within forensic mental health exists, much of this material has a professional focus. Mentally disordered offenders' conception of their own risk is an area that is under theorised (Sullivan, 2005). This should be seen within the context of a limited amount of literature exploring the views of service users within the forensic mental health system generally. The following section aims to examine areas in the literature in which mentally disordered offenders do give an opinion as to their own levels of risk and processes of risk management.

#### *Service users' views on their offending behaviour*

Whilst little research exists in which service users are directly questioned on their understanding of risk, research does exist in which forensic service users gave an

account of their offending behaviour (Coffey, 2012a; Haggard-Grann and Gumpert, 2005; Isherwood *et al.*, 2007). A number of themes emerge from these studies. They are; references to life stressors, drug and alcohol misuse and user perceptions of illness itself. These will now be addressed in turn.

In relation to life stressors, Haggard-Grann and Gumpert's (2005) participants identified problems with significant others (such as family members), stress and pressures within prison or forensic hospitals. Learning disabled men in Isherwood *et al.*'s (2007) study cited a number of social factors for offending, including feelings of vulnerability from others, feelings of isolation, experiences of victimisation and interpersonal difficulties. The influence of anti-social companions was also a theme within the research. This took a number of different forms. In some instances associating with anti-social peers was seen to heighten the risk of violence because aggression was seen to be a more common form of expression within these groups. Consequently, violence was seen as necessary within such settings with one participant stating, "In some circles and in some social groups there is nothing that they understand but violence, unfortunately" (Haggard-Grann and Gumpert, 2005, p. 206). In other instances violence was perpetrated to impress peers (Haggard-Grann and Gumpert, 2005; Isherwood *et al.*, 2009). The participants in Isherwood *et al.*'s study all suffered from a learning disability and highlighted their own vulnerability. In these cases, peers were sometime seen to have initiated offending and then left the less able offender to deal with the consequences.

Drug and alcohol misuse was seen by service users as a factor which might make offending more likely (Haggard-Grann and Gumpert, 2005; Isherwood *et al.*, 2007).

In these cases, substance misuse was seen to bring about disinhibition which might then lead to offending, either through providing 'dutch courage' (Isherwood *et al.*, p.229) or through causing mental instability. The interaction between drug misuse and other factors were seen to be complex with a number of participants giving nuanced accounts of the way in which they interacted with social or biological issues. For example, one participant stated, "I would say that 25-30% of the violence was caused by psychological pressure, 40-50% caused by the cocaine and the rest was trying not to lose face in front of a friend" (Haggard-Grann and Gumpert, 2005, p.206).

Service users often referred to the illness itself as an explanation for offending. In his qualitative research of service users subject to section 41 MHA, Coffey (2012a) identified 'illness as mitigation' as a theme amongst users seeking to justify their offending. He illustrates this point through providing two accounts from service users who described incidents of fire-setting. Drawing on Scott and Lyman's (1968) theory of the way in which accounts are used to justify actions, Coffey argues that illness is presented as an 'excuse' for offending, in that it allowed individuals to identify an offence as bad or wrong without accepting full responsibility. Similarly, offenders in Isherwood *et al.*'s (2007) research highlighted mental illness as a factor which may cause offending, although other factors such as bereavement, responses to disability and the offenders own interest in offending were also cited here.

#### *Service users' views of forensic hospital provision*

Within the current literature focussing on the views of forensic mental health users, the majority has a strong emphasis on measuring satisfaction towards services

(Robinson and Collins, 1995; Morrison, 1996; Hamilton-Russell and McGregor Kettles, 1996; Huckle, 1997; Ford *et al.*, 1999; Brodley *et al.*, 2000; Walker and Gudjonsson, 2000; Bjongaard *et al.*, 2009; MacInnes *et al.*, 2010; Bressington *et al.*, 2011). Service users' views of risk were largely absent from this research. Where the issue of risk was included this was generally implicit and references to service users' perception of risk within this literature usually related to issues around their own safety (Ryan *et al.*, 2002; Sainsbury *et al.*, 2004).

Research elsewhere indicates that mental health service users do use the concept of risk to understand their situation, but that they hold different concerns to those of their care staff (Manthorpe and Alaszewski 2000; Godin *et al.*, 2006). Specifically, service users held within forensic hospitals were concerned about violence from other in-patients, risks of institutionalisation, loss of family contact and detrimental effects from prescribed medications (Bressington *et al.*, 2011; Huckle, 1997; Godin *et al.*, 2006; Sainsbury *et al.*, 2004; Ryan *et al.*, 2002). Service users were acutely aware that their behaviours were regularly monitored and reported upon by staff and that these judgements then formed the basis of discharge or leave decisions (Godin *et al.*, 2007; Davies *et al.*, 2008). Service users' views towards the use of risk to make these decisions varied. For example, one participant in Rees and Waters' study (2003) appeared largely positive stating, "yeah – risk assessment affects your parole because if you're no risk then it's alright to go out in the community – go off on your own" (p.18). However, in other cases service users saw such processes as unjust, with a participant in Coffey's (2008) study likening hospital discharge to a prison tariff system and complaining that he had 'served his time'. In cases where service users were aware of staff protocols, they tried to second guess staff

assessments (Davies *et al.*, 2008) or avoided voicing open resistance on the grounds that this might have been interpreted as high risk behaviour (Coffey, 2011).

### *Service users' views of risk within conditional discharge*

Other research has focussed on service user perceptions of the social supervision process (Coffey 2011; Dell and Grounds, 1995; Coffey, 2012b; Riordan *et al.*, 2002; Coffey, 2012a). Within this literature service users can be viewed to be primarily concerned with the risk that the order may pose to them. A common worry amongst participants was reported to be the threat of recall. A number of quotations from service users illustrates that the rationale for recall is believed to be very open. For example, "they don't have to have a reason to recall you; they could just say he's not coping let's put him back" (Dell and Grounds, 1995, p.67). In addition to this, in some cases restrictions that were placed on service users were seen to prevent them from leading a 'normal' existence (Coffey, 2011; 2012b). Coffey notes that whilst service users tended to see themselves as having been deviant in the past, mental health professionals tended to frame them as being deviant in the present. This dissonance between positions caused a number of tensions in regard to continued supervision. Whilst the degree of supervision varied, a common complaint was that supervision was overly intrusive. This was a concern to service users living in the community in that it was seen to limit their ability to re-integrate. For example, "...see, when you've been discharged from hospital on a 117, you get people coming to your house with briefcases, and doctors and nurses and all that sort of thing. It looks a bit funny, you know", (Coffey 2012b, p. 474). However, it should be noted that responses to social and psychiatric supervision were not wholly

negative, with a number of service users citing the benefits of the support received from services (Riordan *et al.*, 2002; Dell and Grounds, 1995).

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### *Summary of service users' views of risk*

The literature which explores the views of service users subject to section 41 MHA gives some indications of how they conceptualise risk. Recent research indicates that service users do use the concept of risk to think about their own experiences but that they have different concerns to that of mental health staff. The research suggests that service users are primarily concerned about the risks posed to them. Within hospital this may be risk of violence from other patients, institutionalisation, loss of contact from family and effects from medication. In community settings service users refer to the risk that intensive monitoring may pose to effective community integration. However, the current research tends to indicate that although forensic service users have been able to provide nuanced accounts of their offending, they have tended to express less concern about their potential risk to others. This may be because mentally disordered offenders see their offending as a past rather than a current identity. It may also indicate that service users are not engaged by service providers in the process of risk assessment and management plans.

### **Social work decision making around risk**

As the research evidence about how forensic social workers manage risk is somewhat limited, I end this chapter with a consideration of how social workers conceptualise and negotiate risk in other areas of practice. Current research evidence drawn from social work practice as a whole suggests a mixed picture as to



the nature of social work decision making around risk. Research carried out with social workers employed by older adult services tends to suggest that workers are prone to act defensively. Qualitative research by MacDonald and MacDonald (2010) notes that when intervening with older adults with dementia, social workers tended to favour risk-based and actuarial based approaches (by which they mean approaches in which social workers advised users about risk of harm) over approaches that were focussed around users' rights. Similarly Taylor's (2006) research into decision making by social care and health workers engaged with adults assessed risk notes a high level of defensive practice. In his research workers focussed on the following paradigms:

1. Identifying and meeting needs
2. Minimising situational hazards
3. Protecting this individual and others
4. Balancing benefits and harms
5. Accounting for resources and priorities
6. Wariness of lurking conflicts

Taylor notes that workers tended to use paradigms individually rather than collectively. In cases where one paradigm was seen not to fit an alternative was tried. He argues that decisions tended to be made on the basis of defensibility rather than on the basis of what was just. Whilst workers did endeavour to weigh potential benefits against potential harms, greater weight tended to be given towards harms that might occur.

Research of decision making by Australian social workers carried out by Stanford (2010) illustrates that social workers do not always act defensively when making risk decisions. Her research indicated that social workers had a tendency to link the concepts of risk to individuals rather than to contexts. Consequently when risk was

spoken of it was generally attached to a service user who was seen as being 'at risk' or 'a risk'. Similarly social workers were viewed as being 'at risk' or 'a risk'.

Consequently risk was viewed as a personal rather than systematic issue. Stanford notes that risk was conceptualised as a problem within social work accounts and consequently was viewed as a negative construct. Risk was also constructed as intrinsically moral with service users or social workers being identified as being either good or bad within these accounts. Fear was a dominant theme within the research, with social workers fearing negative reactions from colleagues, violence from service users and fear that they might inflict harm on service users. Stanford concludes that social workers in her research resolved the tensions between risk taking and avoidance through moralising their clients. That is, service users tended to be positioned as either innocent or at fault. Based on this judgement, social workers made decisions as to whether they should act on behalf of service users or should adopt a more risk adverse form of practice.

Research by Warner and Gabe (2008) indicated that social workers assessment of risk is affected by gender. Their research used a mixed-methods approach to analyse 33 social workers' risk categorisations. They found that whilst both male and female social workers were likely to view men as being high-risk, female social workers identified more clients as high risk overall and were more likely to identify women as falling within the high-risk category. They concluded that whilst both male and female social workers were likely to identify clients as high-risk on the basis of previous violence, female social workers were more likely to identify women as high-risk in cases where they were seen to violate gender norms.

Although social workers are compelled to comply with risk assessment protocols, informal risk logics can also be seen to affect decision making. Broadhurst *et al.* (2010) examined the way in which informal logics were used within different childcare settings (based on participant responses to case studies). The authors were able to identify three key elements of the informal logics of risk within these settings. First, the logics of risk management were seen by workers to be reflexive, in that responses needed to be tailored to the specifics of each case. Second, risk decisions were seen to be affected by social relations within social work teams. In other words, team cultures and the nature of relationship between service user and worker may prompt both unique and habitual responses. Third, 'a multiplicity of rationalities' were evident in practice. In other words, formal risk decision making tools were referred to, social workers' sense of empathy, compassion and sense of duty to the service user also affected decisions.

## **Conclusion**

A review of the current literature relating to mentally disordered offenders' views of risk indicates that this is an area that is under-developed. This is perhaps surprising given assertions that the management of risk has come to dominate the way in which mental health services are organised (Peay, 2007). The current forensic mental health literature leaves a number of gaps in our understanding of service users' views of risk. In this concluding section I show how these gaps give rise to the research questions before moving on to discuss the theoretical frame for the study.

Current research into forensic service users' views of risk tells us a number of things. Risk was generally seen by service users to be historic rather than current and they were concerned about the risks that treatment or supervision posed to them. Research exists examining mentally disordered offenders' views of offending, although with the exception of Coffey' research, this is not specific to those subject to section 41 MHA. There is therefore further scope to examine how far offending behaviour is seen by this group, with a specific focus on the way in which such behaviour is categorised. This chapter has established that the concept of risk is important to those supervising service users (although viewed differently within professions) and that risk reduction is viewed to be the main purpose of supervision. Given this, it is important to establish what the purpose of supervision is seen to be by service users themselves and how far they feel they can influence it. This also raises the issue of whether service users agree with the accounts of risk that are given by their supervisors and how differences of opinion are negotiated.

Having outlined questions arising from the current literature, I now move on to discuss the theoretical assumptions which might be tested within this thesis. In Chapter Four and Chapter Six I examine the ways in which individuals negotiate labels that have been given to them by legal and medical professionals. Labelling theorists such as Scheff (1966, 1974) have argued that individuals who are given labels (such as mental illness) accept these roles as a process of 'secondary deviance'. This research will examine how individuals accept or reject given identities and the degree to which they feel that they have the power to do so. In Chapter Five and Six, I use governmentality theory to examine the degree to which research participants may be encouraged to adopt and internalise social norms.

Government risk guidance (DOH, 2007b) suggests a model in which service providers are encouraged to use both actuarial and clinical models to assess risk whilst at the same time including service users in the formation of risk plans. This system appears in principle to echo Foucauldian themes of governance. However, it is unclear how far these ideals are adopted in practice. This thesis will therefore examine the degree to which service users see risk assessments as encouraging personal responsibility. It will also seek to chart the processes of resistance that this theory often overlooks. The issue of agency will also be used when considering issues of social control. The research findings are used to highlight service users' views towards these controls. In doing so I will also examine the extent to which they feel compelled to conform to social norms.

## ***Chapter Three - Methodology***

### **Introduction**

This chapter outlines the methodology used within the research. The chapter begins by setting out the research questions. It then moves on to describe the methodology including the initial approach to the topic and research methods adopted. A discussion of the methods used and a reflection of the researcher's interviewing style is then provided before the research process is discussed. This section includes a description of the research sites, the process of contacting participants and sampling issues. A description of the research participants themselves is then given. Ethical and safety issues are then discussed before a description of the methods of analysis is given.

### **Research questions**

My research aimed to provide an in-depth analysis of the way in which service users subject to section 41 conceptualised their own risk and the factors shaping these. As stated in Chapter One, the overarching aim was addressed by way of five questions. These were:

- How do service users' view their own offending behaviour and how does this impact on their own sense of identity?
- Do service users subject to section 41 of the MHA in the community view themselves as being a risk and do they believe that they have constituted a risk in the past?
- Are service users aware of how their risk is conceptualised by their multi-disciplinary team?

- How far do service users' perceptions of their own risk vary from that of the supervising mental health teams?
- What do they understand the purpose of social supervision to be and what are their feelings towards it?

## Methodology

In this section I set out the rationale for the research methods chosen and outline the procedures followed. In considering my research design I was guided by a number of factors. Firstly, I was influenced by my own interests in risk as a practitioner and these informed my research objectives. Secondly, my decisions about the research design adopted were influenced by how well the research objectives might be achieved through these means and also by pragmatic concerns. These issues will now be addressed in turn.

### Initial approach to the topic

I will begin by outlining my reasons for focussing on particular research problems and how this affected my approach. As Silverman (2005) notes, research problems are not neutral, but reflect an explicit or implicit commitment as to how the world works. Social work has a historical commitment to widening understanding of service user perspectives. As a social work researcher I shared this commitment, although I was concerned to explore their understanding of dominant policy and professional concerns rather than starting from a position of asking them how they construct their identity, as Coffey has done (Coffey 2011; Coffey 2012b; Coffey 2008; Coffey 2012a). My commitment to this area of research came about due to

my practice experiences within mental health settings, as I noted at the very start of the thesis. I had previously worked as a Senior Practitioner in a Medium Secure Unit and had been involved in lots of multi-disciplinary meetings in which service user risk was assessed with the aid of professional risk tools. These experiences had made me aware of the growing focus on risk within mental health practice. In addition to this I had also become aware that risk assessment processes can be reductive. That is, actuarial or professional models of risk draw selectively on aspects of an individual's lived experience in order to provide probability statements. As noted in Chapter Two, forensic mental health services see risk assessment as their specialism and aim to reduce service user risk over time (although ideas as to how this should be achieved vary amongst professions) (Davies *et al.*, 2008; Davies *et al.*, 2006; Godin *et al.*, 2006; Heyman *et al.*, 2004; Kennedy, 2002). I therefore felt that it was important to assess how service users might view risk assessments and frameworks.

## **Research design**

Having outlined my initial approach to the topic I move onto consider epistemological and ontological concerns before outlining my research design. Researchers in the social sciences have tended to draw a distinction between positivist and interpretivist approaches (Bryman, 2012; Denscombe, 2010) reflecting an ongoing debate between universalism and relativism (Pease, 2010). Positivist and interpretivist approaches are often portrayed as polar opposites, although in practice researchers may draw on elements from each (Pease, 2010). I adopt a predominantly interpretivist position in this research. In doing so I have been informed by symbolic interactionist approaches in that I am aiming to “catch the process of interpretation



through which [actors] construct their actions” (Blumer, 1962, p. 188). As a consequence of this I have used a qualitative methodology which is inductive in nature, aiming to understand the “set of self meanings” (Burke, 1991, p. 837) which mentally disordered offenders draw on in order to consider their own identity and levels of risk. However, as noted in Chapter One, I take the position that mental illness is something that is real rather than being a social construction, but believe that diagnostic categories are socially constructed in order to manage it.

Nonetheless, I feel that it is important to understand how offenders construct their own identities and am aware that interviewees may be more open to presenting their perspectives to those not involved with their supervision (De Gregorio, 2012).

There is some overlap between my epistemological approaches and my ontological assumptions. Distinctions are commonly drawn between an objectivist position and a constructivist position in which reality is seen to be created and negotiated by social actors (Bryman, 2012). As stated in Chapter One, I use symbolic interactionist perspectives in order to examine the “informal aspects of the regulatory process” (Horlick-Jones, 2005, p. 304). Symbolic interactionists studies within mental health settings have focussed on the extent to which rules are constantly negotiated and are therefore socially constructed (Goffman, 1991). Whilst I have been informed by these perspectives I have not adopted a purely constructivist position and have instead adopted what Best (2003) calls ‘contextual constructivism’. Contextual constructionism focusses on the construction of social problems but accepts that these constructions are in part influenced by objective evidence. This approach acknowledges that researchers will make assumptions about the nature of social problems but that such claims should only be viewed as unreasonable where they

damage the analysis. As stated in the introduction, I take a position that mental health problems do exist but that diagnostic criteria are socially constructed and rely on a degree of interpretation by the person making the diagnosis. Similarly, I take the position that the physical assaults (such as wounding) perpetrated by the offenders in this study are real, but am concerned to find out how these actions are understood and represented by the offenders themselves.

When approaching this topic, consideration was given to the type of data which would best elicit mentally disordered offenders' view of risks. As stated in the previous chapter, Government guidance to mental health practitioners has encouraged them to adopt actuarial tools alongside clinical decision-making (DOH, 2007b), although in practice clinicians may continue to resist this (Maden, 2007). This push towards greater quantification might be seen to be in parallel with increased actuarial tendencies within the criminal justice system (Peay, 2007). However, these approaches do not shed light on how risk is understood by service users. My primary concern was to understand how mentally disordered offenders interpreted and understood notions of risk and so a number of qualitative techniques were first considered. There are a number of qualitative approaches which might be used to gather the experiences of individuals about a type of phenomena. These methods include ethnographic approaches, focus groups and interviews. I decided to use one-to one interviews for a number of reasons. Ethnographic research has been used to good effect in forensic mental health research and has been largely concerned with observing how processes of risk management are experienced by service users and staff (Davies, *et al.*, 2006; Godin, *et al.*, 2006; Davies *et al.*, 2008). Whilst such an approach might offer a good understanding of how formal and

informal risk management strategies are enacted within hospitals, I was primarily interested in the way that supervision was experienced in the community. Service users subject to section 41 MHA tend not to be located together in the community and so such an approach seemed limited. Focus groups offered an alternative way of talking to service users about risk. However, I felt that there would be a number of barriers towards taking such an approach. Firstly, the majority of offenders that I interviewed had committed serious offences. In some cases their index offences had been reported in the press and considerable caution was exercised by service users and their mental health teams about keeping such information confidential. Secondly, I was aware that those subject to section 41 tended to be located across a broad geographical area, which would be a major challenge for the organisation of focus groups. For both these reasons, I opted to use one-to one interviews as this approach was both more realistic in terms of practical organisation, and enabled me to gain elaborate and detailed answers to the research questions posed.

Rapley (2004) has argued that there are two main traditions of qualitative interviewing. The first is 'interview-data-as-resource' in which the data collected are seen as reflecting the reality of the person being interviewed. The second approach is 'interview-data-as-topic' in which the data generated are seen to be a collaborative construction between interviewer and interviewee. He argues that the 'data-as-resource' approach has undergone an extensive critique on the grounds that it ignores the interactional nature of interviews and that interviewees may be concerned to present themselves as 'adequate interviewees'. I would concur with such criticisms and would view my interviews as producing accounts by participants rather than active truths, in that I was aware that the interview took part within a

wider social arena from which research participants drew meaning (Silverman, 1993). In doing so I accept that individuals may interpret similar events differently. However, this is not to say that I view these accounts only as 'constructions'. Rather, I concur with Miles and Huberman's (1994) position that social phenomena exist not only in the mind but also in the social world and that human meanings are worked out within these structures. Whilst knowledge within society is a historical product, meaning-making by individuals forms an important part of the social world and my goal here is to reflect the complexities of these meaning and to theorise how they relate to other social systems and beliefs.

Although my research was primarily qualitative I was also keen to understand the ways in which these perceptions differed from those of professional staff. I therefore adopted a quantitative approach to examine this aspect of the problem which is described in the section below. This data formed a small part of the research overall and used a small sample, but gave an indication of how service user and staff assessment of risk might compare within the participant group.

## **Research methods**

The following section outlines the approaches that I took to interviewing research participants. In order to make my approach explicit I here describe the structure of the research interview, before reflecting on my own approach to interviewing.

## **The structure of the research interview**

Each interview with research participants was split into two parts. The first part of the interview was qualitative. In designing the interview I needed to consider the degree of structure I wished to impose. As Bryman (2012) notes, a school of thought exists that the use of any structure or interview guide will prevent access to the 'true' world views of interviewees. Whilst I accepted that such structures may lead to a degree of containment, I felt that this was warranted as I aimed to focus on a number of specific issues around risk. A semi-structured format was used as this enabled me to explore broad thematic areas relating to interviewees' views of risk whilst allowing me the freedom to probe interviewees or to ask them to expand (May, 2011). Prior to beginning the research interviews I drafted a list of questions (Appendix Seven). The questions focussed on a number of areas. Participants were asked how they came to be on the order in the first place and why judges or other individuals felt that they needed to be on it. I also asked service users about their conditions including their understanding of what these conditions were and how they affected them. Interviewees were asked for their views about what the purpose of social supervision was and how it affected the way that their community mental health teams worked with them. They were also asked about the roles of their social supervisors, supervising psychiatrists and the MOJ. I asked those whom I interviewed about their risk assessment and whether they felt that it was fair and how far they were able to influence the content of it. I also asked them about how they felt that their community mental health teams viewed them and whether they felt that they still posed a risk to others.

In the second part of the interview I moved to a structured pre-coded set of

questions. Structured interview formats are associated with survey design and adopted in order to provide a greater degree of standardisation of explanations (May, 2011). This attempt at standardisation had two purposes here. First, I began by asking participants to name their conditions of discharge. The aim here was to see whether they understood what their Ministry of Justice conditions were.

Consequently they were asked to recall their conditions in list form, mirroring the way that they would have been set out by the MOJ. Second, I asked them to look at a professional risk screen from one mental health trust. As I have noted earlier in this chapter, risk assessments are reductive in that they require an individual (usually a professional) to decide whether a certain action constitutes a risk against certain criteria. Having gained a qualitative account of service users' views of risk I was interested to assess how they defined their own risk when made subject to such processes. They were used in this context in order to see how participants would rate their own risk if limited to using professional risk categories. I asked them to indicate which categories of risk had applied to them either now or in the past. I preceded this request with a brief explanation of what a professional risk screen was and how they were used by mental health teams. As the rate of literacy amongst this service user group is low, I read out the descriptions on the risk screen and asked participants to tell me whether each descriptor applied to them or not. The risk screen itself was divided into categories such as 'suicide and self harm' and 'risk to others' and I would make participants aware each time we had reached a new category by making statements such as "the next group of questions deals with risk of suicide and self harm". A number of the risks listed were written in professional language and I therefore provided simple explanations to participants in addition to the professional headings. For example, after asking participants whether they had

experienced 'violent command hallucinations' I would go on to explain that what I was asking them was whether they had ever heard voices telling them to harm themselves or other people.

## **Manner of interviewing**

As Scourfield (2001) has argued, interviewing is a dominant method within social work practice. Although I have received some training in qualitative interviewing through the professional doctorate programme, my experience as a social care worker and social worker precedes this and so it is useful to outline this here. In doing so, I make connections with the literature on qualitative research interviewing.

Prior to training as a social worker I undertook several counselling courses which were based on Egan's (2007) Skilled Helper model. This method of counselling emphasises the need to adopt good eye contact, an open body posture and a relaxed manner. It also promotes the use of active listening and appropriate empathy. The model encourages the use of open-ended questions, paraphrasing and reflecting, summarising and the appropriate use of silence. It also advocates the use of limited self-disclosure. My subsequent social work training was based on Koprowska's (2003) model, which also utilised Egan's model, but also encouraged students to be an 'observing self-system' with the aim of enabling them to see themselves from more than just a personal perspective. Whilst Egan's model aims to help service users to define their problems and find resolutions to them, this was not my aim within the research setting. Rather, I drew on these skills selectively. The techniques had commonalities with interviewing techniques within qualitative research methodology. I aimed to build a rapport with those that I interviewed

adopting Spradley's (1979) approach of starting with descriptive non-threatening questions. Having established a rapport, I aimed to encourage participants to describe and expand on their experiences. I would generally ask what Kvale (1996) terms as 'introducing questions' (such as asking participants how they came to be made subject to section 37/41) following these up with non-verbal cues and verbal prompts (such as 'yes', 'ok', or 'right'). I also tended to paraphrase what the participant had said in the hope that this would prompt them to develop their ideas. Rapley (2004) argues that the issue of interaction within research interviews is hotly disputed with some arguing that it affects neutrality. On the one hand interaction can be viewed as a bad practice on the grounds that it will contaminate the data and on the other hand it can be viewed as necessary to minimise hierarchical power relations which might discourage disclosure. As Rapley notes, this distinction is a false one as research interviews can never be entirely neutral by virtue of the fact that the interviewer decides which part of the answer to follow up. My preference within interviews would be to begin by asking open questions but then to test the boundary of a view put forward by participants through what Kvale refers to as 'interpreting questions' in which I sought to clarify an interviewees interpretation of events or concepts. For example, in a case where a research participant said that the Home Office were always supportive of his best interests, I asked how he squared this with his recall back to hospital which he had felt was unwarranted.

As mentioned my social work training had encouraged me to reflect on the way in which service users might view me (Koprowska, 2003). This concept might be seen to be similar to notions of 'reflexivity' in qualitative research literature. This concept has been interpreted differently by different traditions of research it can broadly be



understood to relate to a process by which researchers are encouraged to reflect on how their own social background, appearance, assumptions and behaviour might impact on the research process (Finlay, 2002). A number of my own characteristics may have contributed toward the way that participants viewed me. In terms of my visible characteristics I am male and would describe myself as mixed race. Although my father was African, I am quite light skinned and people often struggle to categorise my race seeing me variously as white, Asian or Mediterranean. I dressed in smart-casual clothes for the interviews and my speech would generally be described as middle class. The issue of gender was never explicitly discussed within the interviews and so it is difficult to know how this might have affected interactions. I disclosed my ethnic identity to a couple of the black participants which I did without thinking. With hindsight, I believe that I would have adopted this technique to build rapport. I had provided potential research participants with information stating that I was a social work researcher. Overall I noted that individuals tended to interpret my identity in quite different ways and that this perception often became evident towards the end or after the interview. In one case a participant seemed to see me as a mental health worker and made a statement of thanks towards his mental health team at the end of his interview. Conversely, another participant who was hostile towards mental health services told me afterwards that it was good to be able to talk to somebody important about how bad mental health services were.

Interviewing individuals about risk has certain problems. The introduction of the concept of risk can encourage individuals to view their problem through this lens where otherwise they might not, leading to a circularity in risk theorising (Green, 2009). As my research was concerned with the way that individuals understood risk

practices within mental health it was important to ask them specifically about this. However, I generally tried to avoid using the term 'risk' initially, particularly when talking about ways in which service users conceptualised their offence. In cases where they used the term to describe their experiences then I would ask them to elaborate on what this meant to them. Unless participants themselves mentioned the concept of risk I tended to leave questions dealing with their views of risk assessments until the latter part of the interview.

Interviews took place in either the participant's home or in a health and social care setting. The choice of setting was generally guided by the interviewee's stated preference, although in two cases I was advised not to conduct interviews in the participant's home due to safety issues and so arranged to interview them in community health settings as a result. All interviews were recorded. The majority of interviews took place with just the interviewer and interviewee present, although one participant arranged for her sister to attend for support and an interpreter was present at a further interview.

## Research process

In this section I set out some of the issues involved in accessing research participants. In order to contextualise this process I begin by describing the research site before highlighting the processes that I went through in order to contact this hard to reach group. I then go on to describe how I identified my sample and the characteristics of these service users.

## **Research site and access**

My research was conducted in three mental health trusts in England which I have identified by pseudonyms. Mental Health Trusts were created as a result of the Government's NHS Plan (DOH, 2000) which required health and social services to work in partnership. There are currently 58 specialist mental health trusts providing in-patient and community care (NHS Choices, 2012). The largest of the trusts that I researched was Kingsbridge Mental Health Trust which covered a large geographical area including two cities and rural areas. I chose Valleywoods Mental Health Trust and Leesborough Mental Health Trusts in addition once it became clear that Kingsbridge alone would not provide a big enough sample. The three sites were geographically close to each other. My main reason for choosing them was that my post as social work senior practitioner in a medium secure unit afforded me access to social supervisors in these areas.

In order to recruit participants I had to convince a number of gatekeepers that my research would be properly conducted and beneficial. The difficulties of achieving access are well documented in sociological research literature (Scourfield and Coffey, 2006). Bryman (2012) has observed that gaining access to research participants is a political process. He writes that organisations will inevitably have concerns about potential costs to their finances or reputation. Consequently, access to research participants is arrived at by a process of negotiation. In order to gain access to research participants I had to pass through three layers of gatekeepers.

Service users subject to social supervision are provided with mental health services by both social services and health. As part of the social supervision process they

are supervised by social supervisors and psychiatrists. The Research Governance Framework for Health and Social Care states that, "no research study within the NHS involving individuals, their organs, tissue or data may begin until it has a favourable opinion from a research ethics committee" (DOH, 2005, para 3.12.1). I was advised by the Head of Research and Development for Kingsbridge Mental Health Trust that service users subject to section 41 MHA continued to be seen as patients post-discharge and consequently I applied for ethical approval from an NHS Research Ethics Committee (REC).

Making an application to an NHS REC is a lengthy process. An online application needs to be completed which consists of 70 questions. The application form requires investigators to give the scientific justification for their research. In addition a comprehensive summary of the methodology, design and research methods is required. I also had to provide a research protocol, interview schedules, information sheets and copies of Cardiff University's insurance arrangements. Providing such a comprehensive plan of the research at the outset had both pros and cons.

The advantage of this requirement was that it forced me to think carefully about my research design. I was aware that I would need to justify my research to a panel that would not have a background in social research. Whilst some researchers have been critical of a biomedical bias in such panels (Social Research Association, 2003), I found the process forced me to consider how I could explain sociological concepts concisely. The NHS REC application process also requires researchers to consult users and carers in the design of their research. This requirement was in line with social work values in which the involvement of service users and carers is

encouraged. The British Association of Social Work (BASW) states that social workers should,

seek to work together with disempowered groups, individuals and communities to devise, articulate and achieve research agendas which respect fundamental human rights and aim towards social justice (BASW, 2002, para 4.4.4.b).

In order that I might utilise service users and carers within the research process I set out to consult with service users and carers about the research design. I interviewed two carers whom I contacted via a carers' worker at the mental health charity Rethink. I also sought feedback from two service users subject to section 37/41 MHA at the hospital at which I was employed.

Having done this, my research proposal was scheduled into a local panel for scrutiny. The panel sat on 21.08.08. My main concerns before attending the committee were that they would require me to remove some of the questions from the semi-structured interviews on the grounds that they might be distressing for participants. However, this did not arise as a major issue. The committee asked me to provide further details on a number of issues. I was requested to submit a peer review, to comment on the length of time that the interview may take and to consider simplifying the consent form. I was also asked to outline the consultation with service users and carers in more detail. I responded to these requests by letter on 17.11.08. In addition to applying to the NHS REC I was required to make an application to the Research and Development Department of each NHS Trust. This was a relatively straightforward process. As each Trust required ethical approval from the REC, little extra information was required from me. Local Trust Research Departments forwarded my proposals to the lead for adult services and approval was duly given.

## **Sampling**

One of the first problems that I encountered in the research was identifying potential participants. Figures issued by the MOJ (2007) accessed at the beginning of the research indicated that the number of service users detained under section 37/41 MHA in England has increased steeply between 1996 and 2006. In 1996, 1,626 people were detained under section 37/41 MHA. This number has risen every year except 2003 (when there was a small reduction) to reach 2,492 in 2006. It is unclear why the imposition of this section has risen so sharply and the figures need to be viewed in the context of a 50% rise in the prison population between 1995/6 and 2005/6 (Mental Health Act Commission, 2008). However, whilst it was useful to be aware that admissions under section 37/41 had increased, this did not assist me in identifying conditionally discharged service users in the community. Published MOJ statistics do not provide these figures and the statistics detailing discharges to the community merge all restricted patients together (including prisoners who have been transferred to a psychiatric hospital). I contacted the MOJ by telephone and was put in touch with a manager at the unit with the responsibility for research. He informed me that the MOJ organised its cases alphabetically by the surname of service users and that it was not possible to divide cases in respect to geographical area. It was therefore not possible to accurately calculate how many potential participants were residing in each mental health trust.

In order to identify suitable research participants I contacted team managers in each mental health trust and asked them to provide me with the contact details of social supervisors and supervising psychiatrists in their area. This technique was usually successful, although in some cases team managers did not return my calls. In order

to compensate for this I also contacted Mental Health Act Administrators in each area and asked them for details of social supervisors. Having identified social supervisors, I contacted them by telephone and asked for details of how many people they were supervising and who the supervising psychiatrist was. A letter explaining the research was then sent to them (Appendix One). A copy of the information sheets and semi-structured interview were offered if they required it. Social supervisors and supervising psychiatrists were asked to outline whether there were any current mental health problems which would preclude an interview with the service user that they were supervising from taking place. In cases where such issues were identified, service users were not contacted. A further letter was sent to social supervisors and supervising psychiatrists in such cases several months later to ask whether these issues remained or whether an interview could now take place.

## **Research participants**

In cases where no issues preventing contact were identified, a letter (Appendix Two) and information sheet (Appendix Three) was provided to service users through their social supervisors. The letter outlined the purpose of the research and what the research would consist of. Potential participants were invited to pass on their name and contact details to the researcher. The names of those who agreed were given to me through the social supervisors.

Service users who agreed to take part in the research were contacted by telephone or letter in order that an interview time could be arranged. During these conversations the procedure and purpose of the research was explained again. Service users were given a week to decide whether they wished to take part in the

research from the time of talking to the researcher. A confirmation letter was sent where service users chose to proceed (Appendix Four).

I aimed to conduct what Bryman (2012) refers to as 'maximum variation sampling' in which a researcher aims to ensure a wide variation of cases in relation to their area of interest. In selecting cases I was aware that all service users subject to section 37/41 MHA had been identified within law as posing a risk to the public. I therefore aimed to seek variation in terms of the gender and ethnicity and type of offence committed. Thirty eight potential participants were approached through their care teams. Of these, nineteen agreed to take part and nineteen declined. Fourteen participants were identified but not approached because they met the exclusion criteria (that they were due to be recalled, were subject to a high level of mental distress or that I had worked as their social worker). Service users who agreed to take part gave written consent. The gender balance of participants was roughly equivalent to the restricted patient population between 1998 and 2008 where 11-13% were female (MOJ, 2010). MOJ statistics (2010) do not give an overview of service user ethnicity although research by Coid *et al.* (2000) indicates that black males were 5.6 per cent more likely to be admitted to medium or high secure care than their white counter-parts. There were four black participants in this research which would appear to represent a slightly lower proportion of admissions than those in Coid *et al.*'s sample (which indicates a black population of approximately 25% in medium security). Details of participant age, ethnicity, index offence (the offence leading to the imposition of the order) and legal status are given below. It is difficult to chart with certainty the characteristics of those who refused to take part. In cases where participants gave a reason for their refusal (either to me or the social



supervisor) they normally stated that they did not wish to go over their offending histories again, either because they found this distressing or because they were fed up of doing so. In a number of instances, staff stated that a service user had refused to take part, although the response given seemed to indicate that the staff member thought the interview would be distressing and that the person themselves had not been approached. Although I gained ethical approval to record demographic information of those who refused to take part, social and psychiatric supervisors often failed to send this information when asked. Demographic information was received about seven participants that refused. All were male and in their forties; six were white and one was black. This may suggest that younger participants were less likely to refuse.

Table 1 - Details of Research Participants

<b>Pseudonym of Participant</b>	<b>Gender</b>	<b>Age</b>	<b>Ethnicity</b>	<b>Index Offence</b>	<b>Legal Status</b>
<b>Adam</b>	Male	35	White UK	Manslaughter	Conditional discharge
<b>Ben</b>	Male	39	Black British	Assault and Actual Bodily Harm	Conditional Discharge
<b>Christopher</b>	Male	53	White UK	Actual Bodily Harm	Conditional Discharge
<b>Daniel</b>	Male	59	White UK	Manslaughter	Conditional Discharge
<b>Eric</b>	Male	40	White UK	Arson	Deferred Conditional Discharge (after having been recalled from a Conditional Discharge)
<b>Francis</b>	Male	45	White UK	Actual bodily harm and criminal damage	Conditional Discharge
<b>Grace</b>	Female	45	White UK	Arson	Conditional Discharge
<b>Henry</b>	Male	55	White UK	Arson and burglary	Conditional Discharge
<b>Ian</b>	Male	36	White UK	Actual bodily harm	Detained under section 37/41 MHA (after having been recalled from a Conditional Discharge)
<b>Lamal</b>	Male	26	Somali	Actual Bodily Harm	Detained in hospital under section 37/41 MHA.
<b>Michael</b>	Male	52	Jamaican	Manslaughter	Conditional Discharge
<b>Neil</b>	Male	38	Black British	Manslaughter	Conditional Discharge
<b>Oliver</b>	Male	49	White UK	Sexual offence	Conditional Discharge
<b>Phillip</b>	Male	31	White UK	Malicious wounding	Conditional Discharge
<b>Quentin</b>	Male	47	White UK	Actual Bodily Harm	Conditional Discharge
<b>Richard</b>	Male	34	Polish	Wounding with intent to assault	Conditional Discharge
<b>Sally</b>	Female	39	White UK	Affray and Criminal damage	Conditional Discharge
<b>Tony</b>	Male	35	White UK	Common assault	Conditional Discharge
<b>Vic</b>	Male	36	White UK	Actual Bodily Harm	Deferred Conditional Discharge

## **Ethical issues**

In this section I set out a number of ethical issues in researching this group of service users and show how I aimed to resolve them. I begin with a discussion of social work codes of ethics before considering issues around informed consent, distress to participants and issues of confidentiality. I end this section by considering issues around ensuring my own safety as a researcher.

## **Ethical guidelines**

In planning this research, I have needed to be mindful of a number of ethical guidelines. As a social work researcher I have drawn on guidance by The British Association of Social Workers (2002) (BASW) and the Social Research Association (SRA) (SRA, 2002). I also planned the research in line with the professional requirements expected of me, which at the time of the research were laid down by The General Social Care Council (2004). In addition to this, I am a member of the British Association of Social Workers and drew on their Codes of Ethics (BASW, 2002). This Code of Ethics focuses on both professional ethical requirements and ethical research practice. Lastly, I remained mindful that my proposal would require approval from an ethics committee. Whilst Cardiff School of Social Sciences has a Research Ethics Committee, this committee does not consider clinical research and applicants are directed to an NHS Ethics Committee. I therefore applied for approval from an NHS REC providing evidence of university sponsorship. When thinking through the ethical implications of the research I identified three major issues. These were ensuring that informed consent was given by participants, the possibility of participants experiencing distress including the effect of research on

participants' mental health and maintaining confidentiality.

## **Informed consent**

The principle of informed consent is universally promoted throughout the ethical guidelines that I considered. BASW's statement on research ethics notes that social work researchers have a duty to,

...ensure that subjects' participation in a programme is based on freely given, informed and acknowledged consent, secured through the use of language or other appropriate means of communication readily comprehensible to the research subject...(2002, p. 15)

Informed consent is also stated as a fundamental principle within the Code of Ethics for research taking place within the NHS (DOH, 2005, Para 3.12.1). The BSA does not state that informed consent is an absolute requirement, but states that sociological research should be based on the freely given informed consent of those studied "as far as possible" (2002, para 16). The SRA and BSA codes of ethics advise that in order to facilitate informed consent researchers should ensure that participants understand that taking part in the research is not compulsory. I aimed to ensure that participants understood the purpose and process of the research at the outset through sending them an information sheet. As the level of literacy was poor amongst this group I also ensured that I gave the information verbally in a telephone conversation prior to the research interview. In addition to this I re-iterated the aims and procedure of the research to the participant at the beginning of the research process and made sure that they were happy to proceed before asking them to document this on a consent form (Appendix Five). All participants understood the aims of the research and agreed to consent. In addition to this all participants were willing to consent to me accessing their health and social care records.

## **Distress to participants**

In addition to considering informed consent, I also had to consider whether the subject matter of the research was overly intrusive. The BSA states that researchers, "...have a responsibility to ensure that the physical, social and psychological well being of participants is not adversely affected by the research" (2002, para 13). They go on to acknowledge that sociologists often work with relatively powerless groups and that efforts should be made to establish trust and integrity. I was aware that as the interviews were about social supervision and risk, individuals would be discussing a number of sensitive issues. Participants would be asked to talk about the circumstances which led them to be detained under section 41 MHA. They would also be likely to discuss their experiences in prison or forensic hospitals. Consequently, they might find discussing these experiences distressing.

Whilst I recognised that the discussion had the potential to be upsetting, I was also aware that participants would have had some experience of talking about these issues. All participants would have spent time in forensic psychiatric hospitals. Within this setting they would have experienced interviews in which their risk factors will have been discussed in some detail. I therefore felt that a discussion around risk would be familiar territory for most service users.

Whilst research interviews about risk have the potential to be upsetting, I was also aware that an overprotective stance might stifle the views of service users altogether. BASW's Code of Ethics (2002) argues that social work research should be predicated "on the perspectives and lived experiences of research subjects except where this is not appropriate" (2002, para 4.4.4. b). Although I would not

agree with the qualitative bias that this statement implies I felt that qualitative research into this area was important as the current literature on risk in forensic mental health deals solely with professional perspectives (Sullivan, 2005). I did however, take steps to minimise the potential for upset to participants. The research schedule asked participants to describe their own risk but did not require them to look at their own risk assessments within the interview. Participants were also given the opportunity to discuss any concerns with the researcher at the end of the interview. No data were collected during this part of the process. Routes for obtaining emotional support were given to participants on an information sheet at the end of the interview (Appendix Seven). These included the numbers of local and national help lines and mental health support services in each respective area. Only one participant became visibly upset during the interview. In this case we talked about his feelings after the interview and ways in which he might manage this. In all other cases research participants indicated that they had not felt distressed by the interview.

### **Confidentiality and anonymity**

When planning the research I also gave consideration to the ways in which service user confidentiality should be protected. There were two main issues that I considered. The first was the boundaries of confidentiality that should be offered to service users. The second was the strategies that I should adopt to prevent the data from becoming public.

When considering the appropriate limits of confidentiality I experienced some conflict between my role as a researcher and my role as a social worker. Social workers

have a duty of care to the people that they work with. The General Social Care Council (GSCC) Code of Practice (2004, para 4) stipulates that social care workers must respect the rights of service users whilst seeking to ensure that their behaviour does not harm themselves or other people. This includes the requirement that they should take necessary steps to minimise the risks of service users doing actual or potential harm to others (Para 4.3). The maintenance of safety is also a key feature in the Research Governance Framework for Health and Social Care. These guidelines state that researchers need to give priority to the, "...dignity, rights, safety and well-being of participants" (DOH, 2005, para 3.6.3). Whilst these requirements made sense as a professional worker I was aware that a stringent definition of confidentiality might limit what participants were willing to share with me. I was also aware that the DOH requirements for dignity and safety might not always work together in an uncomplicated way. Participants may find that a less stringent definition of confidentiality allows them greater scope to make their views known and would therefore afford them greater dignity. However, my professional duties as a social worker would require me to report such views if they indicated that the safety of participants or others was at risk. Ethical guidelines by the BSA do not advocate that confidentiality should be absolute, but rather that, "research participants should understand how far they will be afforded anonymity and confidentiality..." (2002, para 18).

In order to fulfil this requirement I felt that I needed to clarify my professional obligations to service users. To achieve this I explained the boundaries of confidentiality both verbally and in writing. Participants were informed that information given within the interview would be treated as confidential. Exceptions to

this would be if the participant indicated that they a) intended to harm themselves or others b) if child protection concerns became apparent or c) they disclosed information in which they incriminated themselves or others in a serious crime. I informed participants that in the event of such information being disclosed it would be passed on to professional agencies as appropriate.

Another dilemma in relation to confidentiality was the duty that I had as a professional to highlight poor practice. The GSCC Code of Practice (2004) requires social care workers to bring to the attention of an appropriate authority operational difficulties that might prevent the safe delivery of care (Para 3.1). This issue was also raised by the NHS REC who made a specific request that I address this issue in relation to the absence of risk assessments in case files. I felt that this was a fair point and addressed it in my subsequent correspondence to the committee in November 2008. I reasoned that service users who are supported by mental health services are subject to the Care Program Approach process. Although different authorities vary in their practices a minimum expectation would normally be that each service user has a current care plan and risk assessment. Service users subject to section 37/41 of the MHA 1983 have a history of presenting a serious risk to others and may also pose risks to themselves. I agreed that where there was no documentation on file highlighting potential risks this would be a cause for concern. I agreed that in cases where the information was not on file then I would speak to the care co-ordinator in order to gather this information. When doing this I would advise them that the risk information was missing. I also agreed that if in the course of the research it became apparent that this was a recurrent issue for a particular mental health trust then I would alert the management of that trust to this problem in



general. I also agreed that I would not highlight individual cases to them as this would compromise participants' confidentiality within the research process. Whilst conducting the research it became evident that a service user's conditions were absent in two cases. In one of these cases the research participant had achieved an absolute discharge at the point at which I was reviewing his file. In the other case I advised his care co-ordinator that these conditions were missing from the file.

In considering the issue of confidentiality I also had to protect the anonymity of service users. In order to prevent identification I provided pseudonyms for both the participants and the geographic areas in which they were situated. This is a common method of disguising participant identity (Bryman 2008). However, this strategy was insufficient in itself. As the SRA note,

Neither the use of subject pseudonyms nor anonymity alone is any guarantee of confidentiality. A particular configuration of attributes can, like a fingerprint identify its owner beyond reasonable doubt (2003, para 4.7).

This point was of relevance when carrying out qualitative research with this service users group. The offences for which service users are convicted can vary in their severity. A number of users had committed offences that had received attention in the local or national press. In addition to this, some were subject to press scrutiny on release. In these incidences I have not reported details of offences which would make participants easily identifiable.

## **Safety issues**

Service-users who are subject to section 41 will have been made subject to such provision due to a concern about potential risk to the public. In order to ensure my own safety I made relevant inquiries to social supervisors in order to ascertain whether there were any known risks to others. I also investigated whether there were any current concerns about the mental health of the service-user which might have increased their risk to me as researcher. Interviews were not conducted if there was an ongoing risk to others which would place me in danger. Participants were normally offered interviews at either a community mental health setting or their home address. However, in cases where risk information identified a potential risk to the researcher an interview at a social services or health facility was offered. In cases where participants were interviewed in NHS or social services buildings, I made reception staff aware of my presence and asked for contact to be made if I did not emerge after a fixed period. In cases where participants were interviewed in their own homes I managed my own safety through utilising the security procedures in the medium secure unit in which I worked. In these cases I made security staff aware of the name and address of the person that I was visiting. Security staff would then ring me if I did not contact the unit and would telephone the police if a response was not received.

## **Data analysis**

In this final section I consider the methods of data analysis undertaken. This section begins with a consideration of the methods of qualitative analysis used with research interviews before describing how service user accounts of their conditions and risk

screens were analysed.

Three types of data were analysed as part of this research. Firstly, research interviews were transcribed and analysed. Secondly, participants' conditions of discharge were collated and compared against conditions given to them by the MOJ. Thirdly, the risk screens that the service users had completed were compared against risk assessments in their mental health care records. Methods of analysis for each of these will be described in turn.

## **Analysis of interviews**

Interviews were recorded and were transcribed. I paid for the majority of interviews to be transcribed, although I would listen to the transcript again and correct any typing errors or instances where typists had altered the dialogue in any way. The data were then coded. I initially used what Coffey and Atkinson (1996) refer to as a 'code and retrieve' approach. That is, data was analysed for concepts and these concepts were grouped together. In analysing narratives I did not hold the view that they were uniquely biographical or autobiographical materials but rather viewed them as an instance of social action; that is a site where recurrent social structures and conventions might be recognised (Atkinson and Delamont, 2008). When examining the data I tried to examine the function of what and how I was told (Coffey and Atkinson, 1996). In this respect I was influenced by theory in which accounts are used to examine the ways in which individuals justify and make sense of their actions against socially accepted norms of behaviour (Matza and Sykes, 1957; Scott and Lyman, 1968). Nvivo software was used to organise and code the data. A coding frame of nodes can be seen at Appendix Eight where a coding frame is

presented. I initially adopted a strategy informed by grounded theory in which data is openly coded line by line in order to identify problems and how they are being resolved and are subjected to a process of 'constant comparison' where codes are compared from one interview to the next (Glaser and Strauss, 2008). Although it was helpful to start identifying codes at an early stage I found this method did not bring about a sharpening of concepts as envisaged by its authors. Later versions of grounded theory have proposed models of 'axial coding' in which data is broken up and reformed into new ways (Corbin and Strauss, 2008). However, this approach seemed unsatisfactory in that it ignored the context from which various findings emerged. In order to resolve this problem I went back to the data and re-coded the data looking for wider patterns and identifying surprising phenomena and inconsistencies (Hammersley and Atkinson, 1995). This initial coding focussed on fairly broad themes such as participants' views on the context of the risk, disagreements or perceptions of staff role in relation to risk. Similarities and inconsistencies between different groups of individuals were noted and used to refine codes. Emergent patterns were related to the existing literature and similarities and differences between previous research findings were noted which further informed the process of analysis. In identifying themes within the data I often used what Silverman (1993, p. 163) refers to as 'simple counting techniques'. That is, I counted the number of participants who mentioned particular themes. In doing this I was not aiming to present data which would be representative of the general population but rather was aiming to avoid anecdotalism.

## **Analysis of conditions**

In the second part of the interview I asked participants to name their conditions.

These conditions were then compared against those given by the MOJ or the MHRT. In some cases the MOJ had altered or standardised conditions which had been set by the MOJ, so in these cases the most recent version of the participant's conditions was referred to. I had initially considered quantifying how many conditions that research participants had identified correctly. However, this proved impracticable for a number of reasons. Different judges and MOJ officials had a tendency to format conditions differently. For example, in some cases service users were given conditions which stated each directive under a separate condition. An example of this would be a condition which stated that a service user should "take all prescribed medications". In other cases, several directives were contained within a single condition. An example of this would be a condition which stated that the service user should "abide by the rules of [residential home] and to abide by the instructions of staff and the RMO [Responsible Medical Officer]". This variance in the formatting of conditions mitigated against a quantitative analysis. In order to analyse the conditions I identified cases in which participants had identified conditions correctly; instances in which they had omitted conditions; cases in which they had partially understood conditions and instances in which participants had wholly misunderstood conditions. This form of analysis did require a level of subjective judgement in terms of what counted as a partial misunderstanding. However, I have attempted to make my judgements here explicit through detailing differences between actual conditions and service user accounts in Appendix Nine. A qualitative analysis of themes was also conducted and is detailed in Chapter Five.

## **Analysis of risk screens**

Given that current guidance indicates that risk assessments should be led by

professionals (DOH, 2007b), service users were shown a professional risk screen and asked to indicate whether they had posed any of the risks listed there either now or in the past. The risk screen was based on a tool by one Mental Health Trust and contained 55 categories of risk overall. These data were then compared against a risk screen completed by mental health professionals contained in the service user's medical and social care notes which also recorded past and present risks. A Kappa measure of agreement was used to explore the level of agreement between service users and professionals. This test measures the level of agreement between two raters taking into account the extent to which agreement might occur through chance alone (Cohen, 1968). Data were analysed through using the Statistical Package for Social Sciences (SPSS) version 19.

## Conclusion

As was noted in Chapter Two, qualitative research in forensic mental health has been conducted and this has focussed on areas such as service users' views toward supervision, service user perception of their own identities and satisfaction with services. A number of research projects have focussed on the way risk is constructed and negotiated within forensic services, although this research has been ethnographic, focussing on the social organisation of mental health care rather than focussing specifically on service user perceptions of their risk. In this chapter I have aimed to address my perspectives as a researcher, methods of research and have also aimed to outline the research process.

One of the greatest challenges in this research was gaining access to service users. Whilst my position as a Senior Practitioner allowed me privileged access to some

research participants (through knowing their supervisors professionally), in other cases professional staff could be suspicious of my involvement or would refuse to return my calls for reasons unknown to me. In addition to this potential research participants were not always keen to talk about sensitive experiences and consequently I was more likely to recruit participants who were comfortable discussing issues around their risk. This may have had an effect on the data, although it is difficult to anticipate what this might be.

Reflections on the strengths and weaknesses of the methodological approach have highlighted a number of issues. In depth interviews were useful for getting a detailed understanding of how service users understood the way that their risk was constructed. Most participants were able to give complex accounts of the way in which their risk was assessed and monitored and their place within this system. Although all participants were categorised as mentally disordered in some way this rarely affected their ability to give an account of the way in which their care was organised. With the benefit of hindsight, it might have benefitted the research process to have adopted a longitudinal approach with a selection of the participants. This is because risk categorisations may alter over time and interactions by service users themselves may adapt rather than remain static. My thesis now moves on to consider the research findings themselves, beginning with a consideration of the way in which service users understood their own risk.

## ***Chapter Four – Service User Accounts of Offending, Illness and Identity***

### **Introduction**

This chapter examines the first two research questions set out in my methods chapter. First, the question of how service users viewed their own offending behaviour and how this impacted on their own sense of identity is addressed. Second, the issue of whether service users viewed themselves as being a risk currently or in the past is explored. In order to address these questions this chapter explores the way that service users sought to dignify and explain behaviours that had been identified as risky by others. I will argue that their explanations rested on notions of the kind of person that they saw themselves as being. In other words, participants relied heavily on notions of identity in order to account for their actions. This is not to say that they offered explanations that focussed only on themselves. The stories told frequently sought to provide a context for their actions and also highlighted the views of significant others. The chapter reviews the ways in which individuals negotiate mental illness and offender identities, drawing on a range of theory and research.

Forensic mental health professionals refer to the offence that lead to the imposition of the order as 'the index offence'. I begin my exploration of service user accounts at this point, giving attention to the way that research participants accounted for their offence and subsequent actions. Participants drew on a range of explanations in order to account for this. I begin by examining those who explained their offending as having occurred as a consequence of being ill. I then turn to those who rejected illness explanations and examine techniques which they used to present themselves.



Not all research participants fell neatly into groups of people accepting or rejecting notions of mental illness. A large proportion gave complex and sometimes contradictory accounts. Within these accounts, notions of risk were framed in a variety of ways in order to emphasise the moral aspects of service users' identities. Attention will be given to the wide range of strategies used to achieve this. I will explore differing ways in which participants described mental disorder, notions of risk as fate, hierarchies of risk and claims that their statements were misunderstood. Finally I draw a number of conclusions in relation to what this tells us about service users' understanding of their identities.

### **Participant accounts of the offence and their reasons for offending**

#### **Illness and Responsibility**

At the start of each interview I told participants that I was interested to find out how they came to be on the order (section 37/41 MHA). Participants generally avoided providing details of the offence that led to the imposition of the order. In framing their accounts in this way, the participants shared similarities with Presser's sample of men who had committed violent crimes in that they were concerned to present accounts in which they were "morally decent in the present" (2004, p.86). Michael was an exception to this rule and provided the following full and graphic account of his offence.

*Jeremy: OK. So, um, I'm interested to know how you came to be on the section 37/41 to begin with? Can you tell me how you came to be placed on that section?*

Michael - Well, one day I was in the park watching a game of football. And there were some lads over the other side playing. And one of them kicked the ball over, over my head and went, and one of them went to retrieve it. As he was coming back with the ball he kick it in my back very hard and it hurt me. So I got up and held him and said something like go and eff yourself. I tell him to

eff himself, yeah. He grabbed me, pulled a knife open and stab after this. I don't mind the knife cut my lip, but you see this cut there?

*Jeremy: Right. OK.*

Michael: It leave, it leave a scar.

*Jeremy: OK.*

Michael: And I waited six months. Then I went and killed his girlfriend.

*Jeremy: Sorry, so for six months you said you were?*

Michael: I was looking for him.

*Jeremy: You were looking for him?*

Michael: Yeah but I couldn't find him. So I went to his house one Saturday night and he weren't there. I couldn't find him nowhere. And his girlfriend was in and I cut her throat.

*Jeremy: You cut his girlfriend's throat?*

Michael: Yeah.

Michael's account of his offence concurred with the description in his health and social care file and the seriousness of the harm inflicted was clearly stated. A similarly frank description was given by Grace, describing her offending and her reasons for it. Whilst both these individuals felt that they had been suffering from a mental disorder at the time of the offence a clear sense of the offence itself was presented.

This was in contrast to the majority of other participants who gave extremely brief descriptions of their offences. For example Neil explained his offence in the context of an account of a judge giving him the order, stating that the order was given to him, because of the "...seriousness of my index offence...I hurt someone very bad...". Similarly, when referring to his offence, Christopher simply stated, "I stabbed a guy". Whilst these participants acknowledged that they harmed others, the degree of the harm inflicted was not discussed. Neil's acknowledged that he "hurt someone very bad", underplayed the seriousness of the offence committed, which was manslaughter. Similarly, whilst Christopher acknowledged that he stabbed a man, the seriousness of the attack was downplayed as he had pleaded guilty to attempted murder after stabbing a stranger in the back in a shop. Five of the participants in the

study avoided giving any direct description of their offence. In these cases, the offence was not mentioned at all, but was instead described in passing, usually within the context of a description of their trial. In this way, the reasons for participants' offending behaviours were made implicit through their description of medical and legal processes. The various strategies that participants employed when considering their level of risk in the past will now be discussed.

It was notable that the majority of participants chose to give greater weight to illness narratives rather than giving accounts which focussed on their offence(s). This may be because diagnoses under the medical model are commonly presented as morally neutral (Irving, 1975) and may therefore serve as a justification for offending behaviour. Thus, whilst a serious offence committed as a result of mental disorder may result in the imposition of social control, the diagnosis also has the effect of neutralising the moral agency of the individual. This raises the question of the level of freedom that participants had in defining themselves in this way. As has been discussed in the literature review, labelling theorists (Scheff 1974, citing Rosenhan, 1973 and Temerlin, 1968) have argued that staff impose labels on service users which they are then obliged to accept. These theorists posit that individuals who lack social power are more likely to be stigmatised as deviant (e.g. labelled as mentally ill) and are then treated differently on the basis of this stigmatised identity. However, others have disputed this interpretation with Gove (1982) arguing that mental illness has a biological basis and that those of a lower social status are only more likely to be labelled because poverty increases the risk of illness. However, in addition to this, there is evidence that individuals self-label when seeking psychiatric help (Thoits, 2005) which implies greater individual agency.

The majority of research participants framed their offences as having occurred as a consequence of mental disorder. However, the way in which these service users positioned themselves showed an awareness of how one identity might be adopted to lessen the effect of another. Six of the participants who were interviewed held the view that their offending behaviour was exclusively as a result of their mental illness. Participants in this category accepted that their previous offending had led to them be in a situation in which they were subject to monitoring. Several participants then worked back from the offence and took the view that such support may have prevented their offence had it been provided at an earlier stage. This is illustrated by Neil who describes the judge's reaction to his offence when considering medical evidence.

Neil: His words were "I can see what clearly went wrong".

*Jeremy: Right.*

Neil: "You need to be hospitalised".

*Jeremy: OK.*

Neil: "And I'm giving you a section 37/41".

Through framing accounts of in this way, these research participants provided themselves with a degree of moral absolution for their behaviour. Their behaviour was judged to have been as a result of mental disorder, rather than as a result of moral deviancy. Furthermore, the accounts of events were confirmed by legal professionals, demonstrating that their interpretations were legally sanctioned.

Inquiry reports into mental health tragedies consistently point to professional practice as being deficient in predicting risk and intervening. Such reports are regarded as authoritative and have significant effects on professional practice (Warner, 2006). Adam cited evidence from an Independent Inquiry into his care in order to support

the view that his offence could primarily be explained as being as the result of mental disorder. He said:

Yes it was huge, a huge fuss about it. They brought in something like twenty regulations for mental health teams all over England, creating phone lines and where people go if they need help as I basically slipped through the net. Years of asking for help and it all got cocked up. I didn't get any help and I think eleven or something like that were brought into play. Some new office was created where people take phone, calls off parents who might be worried, or friends or girlfriends who might be worried and think something serious could happen.

Through contextualising his offence in this way, Adam was providing a rationalisation for his actions. He was also giving an opinion as to where the responsibility for his actions should lie. This is not to say that Adam denied that his actions were wrong. Rather the responsibility for preventing his offence was seen to lie not with him but with the professionals who were supervising him.

Whilst many participants referred to a medical model in order to explain their behaviour, some retained an awareness that alternative explanations existed. For example, Neil recounted how an independent doctor at a tribunal questioned his diagnosis of paranoid schizophrenia, suggesting instead that he suffered from drug induced psychosis. Neil laughed when I asked him what he thought about this hypothesis and stated that he did not want to get involved with it. He stated,

Neil: I know, I know that if it was drug-induced psychosis they would have to, to test me in the community.

Jeremy: *Right.*

Neil: In the sense that, and test me off drugs. Off me medication.

Jeremy: *Yeah.*

Neil: and I don't want to take the risk.

In the above section, Neil was acknowledging that the way his condition had been categorised was disputed. Whilst the alternative was not wholly discounted, the medical identity was seen as preferable. In effect Neil was acknowledging that he

did not know which identity was 'correct' but that that accepting a medicalised identity provided him with a greater level of security. Thus, rather than accepting a diagnosis of mental illness as a process of 'secondary deviance' (Scheff, 1966), Neil revealed that he had made a calculated decision to accept such an identity on the basis of probability.

An effect of using mental illness as a means to neutralise moral agency was that the feelings of the victim were rarely considered. Daniel's victims expressed concern about his intent to move to an adjacent county. This resulted in them holding meetings to voice their concerns which resulted in the MOJ excluding Daniel from that area. Within his account Daniel positioned himself as someone who had posed a risk to others wholly as a result of mental disorder. Becker (1991) argues that in cases where an individual is given a particular kind of label, they come to accept this identity as having a 'master status'. It was notable that Daniel accepted a label of mental disorder and that this label was given a 'master status'. However, in this instance, this status was used to mitigate against another deviant identity; that of an offender. Consequently, his risk was seen as having been reduced through effective treatment. Whilst an acceptance of this status served to make him less culpable for the offence, it also provided distance from the experience of the victim. For example, he said,

Of course this is the thing that Mr. Lee [victim] has always been making comments about, the fact that he still feels unsafe. Well he's got no reason to feel unsafe at all, especially from my view point. But of course the point that Keith Johnson [social supervisor] was making is that nobody ever bothered to find out who I am and what I'm doing and how I'm behaving. So it would have been nice if they'd had their meeting at Chapel Farm [Community Mental Health Team base] so that I could have actually gone along to the meeting, answer any amount of questions they wanted to put to me and they could then have discovered for themselves what kind of a person I actually am. Rather

than rely on historic information from the internet and past newspapers which weren't at all enhancing, you know?

In Daniel's case the MOJ expanded the areas to which he was restricted once it became evident that he intended to move to a geographical area that was closer to the victim. This had occurred as a result of a representation made by the victim to the MOJ via a third party. These actions were viewed by Daniel as unjust because they characterised his actions in terms of the impact of the offence rather than on the identity which he was concerned with; which was as a mentally ill man in receipt of treatment.

Whilst a proportion of participants used the medical model as a means to play down their agency in the offending process others provided more complex accounts.

Grace highlighted her inability to access support for her problems in the past. Her account differed from Adam's in that she saw the responsibility for her actions as lying with both herself and society, in that support was not available to her previously. However she described herself as actively seeking help through admitting to her crimes. In this extract she described a series of arsons in which she set fire to cars:

...also with the fires because I didn't sort of like sit and wait around, I would just light them and go. I didn't really know if there was anybody in the cars or it could have blown up I suppose so I didn't think of that at the time. So when I was committing the offence there was no concerns or nothing. But twelve or thirteen hours later it would kick in and it got too much so that's when I went to the police. But I never got caught. I went to them because I know I needed help. They had a rough idea it was me but never had anything to pin on me. So that's why I went to them because I thought there must be people in prison who can help me. And that's what happened.

Grace demonstrated an awareness of the danger of her actions and spoke of feelings of responsibility as weighing heavily on her. In order to resolve this dilemma

she placed herself within the criminal justice system. In doing so she believed that this system might enable her to facilitate a new identity. This narrative views the identity process as a system of control in which “a set of meanings” serve as “a standard or reference for who one is” (Burke 1991, p. 837). This can be seen to relate to Mead’s (1997) theory of identity which was outlined in Chapter Two. In Meadian terms Grace’s account might be seen as the ‘I’ subject acting on the ‘me’ to facilitate a more stable identity. Whilst Grace had aimed to do this through admission to prison she received a diagnosis of personality disorder which was then used as a framework for understanding and interpreting her risk behaviours. Her account differed from those of other participants in that this process was viewed as being negotiated from the outset. Her decision to place herself within the criminal justice system was portrayed as a conscious choice rather than a decision that was taken away from her.

### **Offenders rejecting explanations of mental disorder**

Three of the participants did not accept that they had suffered from a mental disorder. They also rejected the view that they had posed any level of unacceptable risk to others in the past. Their accounts can be seen to offer a justification of their actions through neutralisation techniques (Sykes and Matza, 1957) which were discussed in Chapter Two. Several of these techniques can be viewed within the accounts of the participants denying that they have posed risk to others. The first of these is denial of responsibility. This can be seen in the account of Quentin who justified his attack on others through a narrative which positioned him and his family as under attack from others. He stated that he had been attacked by the council and a supermarket chain (who had sought to take over his land) and the police who had



acted to enforce this. Quentin viewed his attack on the police as a justified defence of himself and his family. Whilst acknowledging that interpretations of responsibility are culturally constructed, Sykes and Matza see the function of denial of responsibility as being to position oneself away from the sense of blame attached to deviation from social norms. The professional interpretation of Quentin's actions was that he was suffering from paranoid schizophrenia. Quentin was aware of this construction of events but rejected it alongside any notion of wrong doing. This was demonstrated in the following account where he recalled that at trial he refused to plead. He said:

Because I thought the police caused all the trouble and Supersaver...I thought I'm not going to plead. I'm not guilty. I'm not going to plead. Why should I plead when I was only doing what was natural like protecting my own property. And I thought I can play ignorant like they can play ignorant. So I thought I wasn't going to bow down to their rules and regulations.

In taking this position, Quentin saw himself as maintaining a position of moral righteousness through protecting his family. In doing so he was also adopting a technique which Sykes and Matza define as, "the condemnation of the condemners" (p.668). This is seen as a means by which offenders may aim to neutralise the effects of their behaviour by concentrating on the motives and behaviours of those who are expressing disapproval. In the above narrative, Quentin positioned his accusers as corrupt and in so doing provided a justification for not adhering to socially sanctioned rules and values.

Techniques of neutralisation might also be used in order to bring about a, "denial of the victim" (Sykes and Matza, 1957, p. 668). Francis utilised this technique a number of times in his account. Although Francis conceded that he attacked his

victim he positioned this attack as a justifiable response to actions by others. He said,

...one of the reasons for being put inside was at one time I sort of lashed out at some woman because she was pissing me off and she was subjecting me with lots of horrible jokes and I got annoyed so I hit her...I was provoked into doing that. I wouldn't normally do that sort of thing. I'm not normally violent but I was provoked into doing that. I didn't even kill her did I?

In transforming the victim into someone deserving of harm, Francis sought to re-position his assault as a justifiable defence of his own position. In addition to this, Francis favourably compared himself to murderers in order to minimise the degree of his offending. In doing so, Francis positions his victim as in the wrong, whilst his actions are seen as being morally justified.

### **Multi-factorial accounts**

Acceptance of a psychiatric diagnosis did not indicate a wholehearted acceptance of the medical model by interviewees. Whilst a number of participants accepted that mental disorder contributed towards their offending, other explanations were offered to justify the context of their offence.

The issue of drug and alcohol misuse was commonly raised by research participants. Research indicates that this issue is a significant problem for users of forensic mental health services. For example, research by Scott *et al.* (2004) found that 51% of a sample being discharged from a forensic mental health unit had significant drug misuse issues at the point of discharge, whilst 40% were judged to have alcohol difficulties. Research participants often stated that drug and alcohol

misuse had played a part in their previous offending or risk behaviours. In some cases they saw their drug misuse and mental disorder as being bound together. For example, Richard saw drug misuse and mental illness as joint factors in making him aggressive towards others.

Richard: I committed a crime. I attacked my father and my mum with a knife as I was ill, I didn't take any medicine and this illness started. I don't remember how it happened.

*Jeremy: Have you been ill in the past or was that the first time?*

Richard: In Italy I was in prison and I started smoking hashish and that's when it was diagnosed that I had some illness. I heard voices and I had strange thoughts and they took me from prison to the hospital in Italy.

In this account, the role of drug misuse in the participant's offending is to the fore. The index offence was judged to have occurred as a result of a combination of illicit drug misuse and mental illness. Richard saw both taking psychiatric drugs and abstaining from illicit drugs as the key elements in reducing future risk. Whilst Richard expressed relief to be away from illicit drugs, it was more common for participants to express a degree of ambivalence to misusing drugs and alcohol. A number of interviewees objected to conditions which forbade them from using illicit drugs or alcohol. Despite this, they generally stated that they appreciated the reasons for such conditions and agreed with the rationale. For example, Sally expressed annoyance that she was given a condition prohibiting her from using alcohol. However, when recalling an instance following an informal admission to hospital she said,

...I ended up in a graveyard with a broken bottle and cut myself up and that's the sort of thing I would do if I was drunk but I don't do things like that if I am sober.

This acceptance of drug misuse as a source of risk was not the case in all accounts and some participants made quite fine distinctions between past and present risks.

For example, Ben rejected his team's view that drug misuse was likely to bring about a future relapse in mental health. He said,

They would say like if I was to have a spliff or a smoke then I would relapse. And I was saying it was not necessarily a relapse but was the company I was with and who was around me and it depended on whatever kind of drugs I was smoking and [whether] I was taking the medication.

In the above quotation Ben was making a number of distinctions. First, his social context at the time of drug use was seen to be important, second, the type of drugs he might use was seen to be important and third, psychiatric medication was judged by Ben to be a protective factor against future relapse. This is illustrative of a proportion of participants with a previous history of drug misuse. Whilst they accepted that drugs and alcohol might negatively affect their behaviour, they differed from professionals in their assessment of how illicit drug use should be constructed. Professional assessments of drug misuse had a tendency to see drug misuse and mental ill health as being inextricably linked. Whilst some participants accepted this view, a significant amount saw drug misuse as a separate issue that should not be viewed within a medical framework.

A number of participants utilised the concept of mental disorder to explain their responsibility for their index offence, but believed that other explanations should also be used to explain their level of risk. Lamal referred to his mental illness in order to neutralise his responsibility in relation to the offence. He said

...when I was in Northfield [Hospital] I kicked off the door and ran away from there. And that was how I ended up hitting the police officer when I was mentally ill in the past.

In this account he cited his mental illness as the reason for the assault and later repeated this assertion stating that he was "not right in the head". However, later in

the interview he ascribed his level of risk to prescribed medication that he was required to take under section.

...the police officer one [the assault on an officer], I was not thinking because all I wanted to do that day was to go to my brother's house. And plus, they gave me drugs. And when you're on drugs, their drugs, their medication, yeah, it's paranoia when you're outside because, when you get addicted to it, yeah. It becomes paranoia when you need their drugs...

Lamal presented a complex and sometimes contradictory account in which mental illness was seen to mitigate against responsibility for the offence. However, in addition to this he viewed the offence as something which was brought about by mental health services in that he saw the effects of psychiatric drugs as being responsible for his behaviour. In this way, Lamal was using a technique of neutralisation (Sykes and Matza, 1957) in that he was "accusing the accusers". Despite using the label of mental illness as a mitigating factor for his offending, he argued that the system was in itself unjust because it did not take account of individual ability. Furthermore, he sought to separate himself from other inpatients through stating that he had 'mental health problems, rather than 'rehab problems' indicating his ability to live independently. Lamal was different from the other participants in that he had not yet received a conditional discharge. His account used several different techniques to justify his actions and these explanations often worked in opposition to one another. However, other participants also interpreted mental illness in ways which differed from professional constructs.

### **Differing definitions of mental disorder**

A notable feature of many of the accounts is that participants provided quite different interpretations of mental illness from that of the treating professionals. This can be

seen in the accounts of both those who reject or partially accept a diagnosis of mental illness. In some instances mental health terminology is used as a means of “accusing the accusers” (Sykes and Matza 1957). For example although Francis objected to being described as mentally ill, he frequently described both his own actions and that of mental health staff as ‘paranoid’. When asked to clarify what this meant, he said:

...everyone’s a bit mental in every sector and they gets panic attacks and aggravated. I don’t get aggravated but some people do. I don’t get irritable I just get depressed. If I’m mentally ill then all it is that I’m nervous and a bit of panic attack. I’m not psychotic, not paranoid than anybody else, not depressed than anybody else so really that makes me normal even when they’re calling me mentally ill.

In this way, Francis normalised medical language and in doing so, rejected the connotations of risk that ran alongside these labels. A similar tactic was for participants to provide their own definitions of mental disorder in order to reject the label that had been given to them. For example, Quentin rejected the label of schizophrenia given to him by medics. He said,

Well some people think that I’m paranoid and I’m not paranoid because I know exactly what went on. And I feel very upset about the way I’ve been treated and about people thinking I’m just paranoid about what’s happened. And I’m not paranoid ‘cos I can remember most of the things that’s happened, and that don’t mean you’re paranoid if you can remember what’s happened.

In this way, Quentin rejected professional labels through constructing his own definition of paranoia. Francis, Quentin and Tony rejected the label of mental disorder outright. However, differences in interpretation as to what counted as a mental disorder were also utilised by participants who accepted that they had suffered a mental illness at some point. These explanations were used to justify differences in an interpretation of events between the participant and staff. Philip was remanded to custody after a serious assault on a family member. Whilst he was

in prison he claimed that he was a member of the IRA and smashed up his prison cell. Mental health staff clearly interpreted his offence as having been linked to mental illness. Philip's risk assessment records two incidents where he threatened family members with weapons and records opinion that he was psychotic in both cases. He was also felt to be psychotic at the time of the assault. His Core Assessment noted that, "Philip himself has never really accepted that he has a mental illness..."

However, this interpretation was not supported by Philip's own accounts of events in the interview. He did agree that he had suffered from a mental illness but his interpretation of this was markedly different from that of staff. He said,

I feel that my mental health issues were strictly stress and depression and anxiety, things like that and anything that I said about anything that was abnormal or strange or not true, was something that I knew enough about when I was saying it. I wasn't saying it because I wholeheartedly believed it, I was saying it because I liked to play up. That's been an issue between me and doctors for a long time, about them saying well, you know you must have believed this and it must be true, and me saying, 'no not at all, just normal'.

This difference in interpretation serves the function of providing a justification for the offence whilst rejecting the diagnosis given by mental health services. Whilst Philip accepted that he suffered from a mental illness, he made a distinction between accepting interpretations that he saw as falling within normal responses whilst rejecting the notion that his behaviour was, "abnormal or strange or not true".

### **Risk as fate**

Whilst acknowledging professional discourses of risk as valid, some participants also maintained a belief in other frameworks that ran counter to these. As noted in

Chapter Two, risk theorists have often drawn a distinction between pre-renaissance views of risk as fate and post-renaissance views highlighting causality. When discussing risk Michael utilised notions of risk as fate, rather than rationalistic models. Whilst he accepted a diagnosis of mental disorder, he saw his life as having taken one of several possible paths. Although Michael broadly agreed that the risk management procedures to which he was subject were appropriate, he also referred to a number of factors which might have changed the course of his life. One of these related to medical treatment. He recalled that he did not accept a doctor's advice to continue taking psychiatric medication and subsequently his mental health deteriorated. However he also provided alternative explanations. Towards the end of the interview he recalled being detained under the MHA for the first time.

Michael: It's like ten years of my life missing, went, went by in a flash and I don't know where it's gone and then I ended up killing a person. And then, you could say I proved them right, but, that I proved them right, but if they did leave me, maybe I'd have found a [inaudible].

Jeremy: *Right, so you think maybe people ought to have got involved in your case a bit quicker?*

Michael: No, no, if I did get help with the housing it would never have happened.

Jeremy: *Right, OK, so it's not so much about psychiatry, it's about other things?*

Michael: General life.

Jeremy: *Yeah.*

Michael: If you're homeless with nowhere to sleep, you would be hot-headed and think you the law, you know what I mean? I would love to know what would have happened in those years if I hadn't missed out on them. But I woke up, they drugged me up and I was helpless after that.

Thus whilst accepting that the rehabilitation that he received through mental health services was broadly appropriate, Michael also held the view that this turn in his life may have been avoided altogether if he had been able to access resources such as housing. He also referred to his relationship with his wife and a subsequent partner as a factor. He compared the quality of his relationship with his ex-wife (who he



described as a woman) against his relationship with a subsequent partner (whom he characterised as a girl) in the following way:

...but when you got a woman she can understand a man. I didn't have a woman I had a girl...So um, my own philosophy of, of being dragged up whatever, um if I had a good woman I wouldn't have been in this situation now.

The participant's account refers to the support that he might have had from his ex-wife and the effect this might have had on his life. Within his narrative he positions himself as vulnerable to factors such as homelessness which he sees as having an impact on the direction his life took. This is not a means of negating responsibility totally. He cites his unfaithfulness as a reason for his ex-wife leaving him (although he downplays his domestic violence towards her). However, whilst mental health services are seen as dealing appropriately with his situation in the present, this view occurs within a wider framework in which he wonders whether the necessity for that intervention might have been avoided. In this way his account shows some similarities with the literature on desistance which highlights the role of social support in preventing future offending (Sampson and Laub, 1993).

## **Hierarchies of risk**

As previously noted, mental disorder can be seen to offer a degree of absolution for offences committed. However, participants also used other strategies in order to differentiate themselves from other offenders. In her study on sex offenders, Hudson (2005) notes that those who accepted the label of an offender utilised a number of distancing techniques, including distancing by category of offence. She argues that offenders are prone to mirror the views of wider society, placing offenders in a hierarchy with sex offenders at the bottom. Participants in this study also referred to

such categories in their accounts in order to position themselves in terms of risk in relation to others. This was demonstrated by Ian who said, “I’m not in [hospital] for [being] a paedophile or sex case. I only stabbed a man”. Through making this comparison Ian was aiming to minimise the seriousness of his own offence. Whilst the offence of stabbing a man may ordinarily be viewed as serious, it is positioned as being a less serious crime than being a paedophile. Similarly, other interviewees, to question their own risk categorisations cited instances in which staff had let out service users who had re-offended. Alternatively interviewees referred to the assumed moral values held by categories of offenders. This was then used to argue that they held a higher moral position through not possessing the characteristics of such groups.

Oliver’s narrative also echoed the view that a hierarchy of offences existed. He had been convicted for sex offences and put forward the view that his crimes put him at the bottom of this hierarchy. He said:

Its like when you do something extremely wrong, dangerous, you hurt children that aspect, that’s the low of the low thing in the eyes of the public. Forget murder, arson anything like that, crimes against children is the low of the low, the bottom of the heap. That’s how I look at it and that’s the way society sees it.

Hudson (2005) comments that ‘shame’ can be seen as a way in which offenders manage their identity. However, in this case, this position is not adopted uncritically and Oliver also refers to the way in which attitudes toward sexual offending have changed. Asked whether his offence would be seen by professionals as a more serious offence than murder, he said,

Oliver: Yes, I reckon because back in the 1970s it wasn’t a big deal was it?  
Jeremy: *What wasn’t a big deal then?*

Oliver: Incest wasn't a big deal.

*Jeremy: So it would have been seen as incest rather than child abuse then?*

Oliver: Yes they put it down as something else, I had a relationship with my sister and that's that but back in 1979 there wasn't a big stigma about it. If you go back to the 1950s there wasn't a big stigma about it but these days it's a big bloody stigma about it.

Thus, whilst Oliver at times used 'shame' as a means to manage his identity, he retained a degree of ambiguity. Whilst on one hand he drew attention to his position as the 'lowest of the low' he also drew attention to the fact that the shame attributed to his offence was societally constructed and so subject to change. In his account he highlighted that his status as a mentally disordered offender protected him to some degree from his status as a sex offender. However, in his account his mental health status was questioned by members of nursing staff who expressed the opinion that he should not be a patient within the forensic mental health system because he was primarily a sex offender. In his interview Oliver outlined complex reasons for offending. For example, he stated that one of the reasons that he offended was as a means to both satisfy his sexual urges and to express his anger against society. For example:

...and it just snaps and you aren't worried about the consequences or anything like that, you just go out and do it just to sabotage, so constructive, when you have had enough of society and then think live outside. It's a bit like a bit of paranoia to a degree on the level of other people. You see them successful haven't done crimes and stuff like that and they treat you like a nice, friendly person and they don't see you as this person whose, they don't know you from Adam, but deep down inside yourself its feeling that, that anger and bitterness...

Oliver therefore outlines a complex set of dynamics in which he shows that he expresses shame for his offences. However, he is also aware of the way in which society categorises his offences. As a result of this he shows that he finds it difficult to accept kindness from individuals because of the divide between their conception of him as an individual and the societal view of him as an offender. This might be

understood through Goffman's (1990b) theories about stigma and information management. Goffman points out that in situations where stigma is not visibly obvious, an individual may not face immediate prejudice, but rather may experience unwitting acceptance. A dilemma is then presented to an individual as to whether they should reveal that they belong to a stigmatised group. In Oliver's account he described situations in which he has revealed his stigmatised identity which has then led to a rejection by others. He described this as sabotage, which implies that he carried out these actions to punish himself. He also described incidences of acting against the order which also worked to confirm his stigmatised identity as a sex offender with mental health problems.

### **Claims of misunderstanding**

A less common way of explaining risk events was to insist that the relevant actions were intended as jokes. These descriptions posit that staff had misunderstood events which had then been interpreted as risks. Humorous statements may be seen as something which reside outside of normal discourse and should therefore not be used to judge an individual (Emerson, 1973). Two participants used this model to argue that their statements were misconstrued by staff. For example, Francis says,

...then they put me in hospital for those two years and didn't let me out and I got a bit pissed off with that so I said I would chop the psychiatrists head off and kick it around the ward. And it was just empty threats something I would never do and they believed me or they pretended to believe me. I think they pretended to believe me. And that's when they locked me up for eleven years after that.

In this section Francis does not allow for the fact that a threat to cut someone's head off may not be seen as an appropriate social response. Instead he felt that his

behaviour was acceptable and that staff had deliberately misinterpreted his intentions. Similarly, Ian stated that he had been unfairly recalled as a result of joking that he intended to kill others. These accounts put forward the view that staff should have been able to read the true intention of the participant despite them having made statements that indicated intent to harm. These accounts are particularly challenging because they question common societal frameworks for understanding threats to others. The potential distress that might be caused to those that have been threatened is not acknowledged. There is also very little understanding from participants of how such statements might be commonly interpreted.

### **Issues of race and gender**

Issues of race have been hotly contested within the literature about mental health. Black people are six times more likely to be admitted under civil section (Harrison, 2002) and are 2.9 – 5.6 times likely to be admitted to secure units than their white counterparts (Dein *et al.*, 2007). A range of explanations for this phenomenon have been given. Keating and Robertson (2004) propose that black service users and mental health professionals fear each other, limiting trust and engagement. Other explanations include a greater incidence in the black population caused by either biological factors or the pressures of migration (Sharpley *et al.*, 2001), institutionalised racism within mental health services (Fernando, 2010), or as a consequence of experiencing socio-economic deprivation (Dein *et al.*, 2007). Although five of the research participants described themselves as either African, Caribbean or Black British, issues relating to race were largely absent from their accounts.

An exception was Michael who was Caribbean and contextualised his first contact with mental health services though describing his appearance at the time. The following section gives a description of this:

Michael: ...I had a fringe.

Jeremy: *Yeah*

Michael: And my beard was down to here and I had a big moustache,

Jeremy: *Right*

Michael: so you couldn't see my lips

Jeremy: *Yeah*

Michael: so I looked like a wild animal

Jeremy: *Right*

Michael: and people were scared of me.

As well as making reference to his 'wild' appearance, Michael spoke about his contact with probation, police and medical services and describes a situation in which his identity marked him out as 'other'. However, this is seen as one of many factors marking him out for attention by mental health services, the other factors being membership of a criminal family and outward hostility to an assessing psychiatrist. Thus, whilst his appearance was seen as a factor which altered the way in which services responded to him, it was seen as one of many factors. In other words, Michael believed that he was identified by services because of multiple identities which marked him out as different.

Of the research participants interviewed, two were women. There are both quantitative and qualitative differences between male and female patients admitted to prisons and secure hospitals. Whilst a full exploration of these differences is outside the scope of this chapter, it is useful to note here that the majority of women admitted to secure services have a diagnosis of personality disorder (Milne *et al.*, 1995; Smith *et al.*, 1991) and that prevalence of deliberate self-harm is much higher

amongst women than men (Burrow, 1992; Low *et al.*, 1997) with Maden (1997) stating that 64% of women compared to 27% of men within Special Hospitals have a history of self-harm. Research suggests that there is a probable link between such self-harm and psychological distress experienced in childhood (Parkes and Freshwater, 2012). Due to there only being two female research participants, it is hard to evidence patterns between their accounts with confidence. However, whilst the women did not explicitly refer to their gender as a reason for offending, both saw their risk to others as having arisen from a desire to hurt themselves. Both Grace and Sally spoke about cutting themselves with knives as a means of punishing themselves. These actions relied on a splitting of the self into component parts. This can be related to Mead's (1997) theory of identity outlined in Chapter Two. To use his analogy, the 'I' and the 'me' can be seen to have entered into dialogue, drawing on feedback from the 'generalised other' (the audience – in this case family, friends and professional staff - giving feedback to the 'me'). The women could be seen as registering negative representations of the 'me' (real or imagined) and reacting to these through self-harm. For example, Grace referred to situations where she felt that she had "let everyone down" saying, "...a lot of the time when I was carrying knives, that wasn't to harm anyone, it was to harm myself really...". In common with Parkes and Freshwater's sample of women, Grace self-harmed in order to gain relief from such feelings but was eventually able to develop alternative strategies. In her case this relied on talking to others about her feelings at times of distress, such as her sister or the mental health Crisis Team. This allowed her to question negative versions of self, allowing for a collaborative manufacture of more positive versions of the 'me'.

Whilst Sally also carried a knife so that she could punish herself, she also described carrying a second knife for the purpose of hurting others. She said,

It's a comfort if you have a knife. It's not to protect myself; not that sort of comfort, it's a power thing as well. I can do this [attack others] and you can't stop me.

In this way, weapons were used as a means of increasing her sense of personal power. Whilst she was aware that these behaviours caused her mental health team considerable concern, she found value in this behaviour because it allowed her to feel that "I am in charge". Her actions can therefore be seen as being a rejection of the socially acceptable 'me' identities held by her team and others. In contrast to Grace, who had resolved the discord between the 'I' and 'me' identities through talking to others, Sally gained feelings of power through rejecting the values of her team.

## Conclusion

In keeping with Presser's (2004) research into the offending identity of violent men, the majority of service users in this study were concerned to portray themselves as moral individuals in the present. The men and women who were interviewed were acutely aware that they had been identified as offenders with a mental disorder. Most were aware that these identities were subject to varying degrees of social stigma. Research participants responded to this dilemma in a number of different ways. In cases where they rejected a diagnosis of mental disorder, techniques of neutralisation (Sykes and Matza, 1957) were used which also had the effect of positioning the action of that individual as moral. However, it was more common for participants to view diagnosis as a labelling process which reflected a social reality (Link and Phelan, 2010 refer to this process as 'soft labelling'). In these cases the



illness was portrayed in an essentialist manner echoing research findings elsewhere in which the 'real me' was seen to be at risk from the illness (Roe and Ben-Yishai, 1999; Wisdom *et al.*, 2008). In giving these accounts, participants referred to the interpretations of influential others (most notably legal experts and mental health professionals), indicating that these versions of the self were "collaboratively manufactured" (Goffman, 1990a). Through referring to illness in this way, research participants mitigated against the moral appropriation normally associated with serious offending. In other words, they were not just providing accounts of illness and treatment but were also minimising the shame associated with violent offending. This had an effect on the way in which some characterised issues of responsibility. In a number of cases the responsibility for the offence was laid at the door of mental health professionals on the grounds that they had failed to assess and treat the disorder. In other cases a focus on the issue of illness also worked to minimise the claims of the victim.

This focus on issues of illness provided research participants with a dilemma, in that mental illness itself was seen as a stigmatised or 'deviant' identity. These problems were dealt with in a number of ways. One method of minimising the stigma from mental disorder was to claim they had recovered or were being successfully treated. These explanations will be considered in the context of the purpose of the order in Chapter Six. However, what I have demonstrated in this chapter is that research participants commonly referred to the concept of illness, but interpreted this concept in a wide variety of ways, some of which diverted notably from the accounts given by professionals in their mental health records. Furthermore, it would be misleading to suggest that all accounts were characterised solely by an acceptance or rejection of

medical models. A large proportion of research participants explained their behaviour through citing multiple factors which were also used to explain their behaviour, such as drug and alcohol misuse, fate or through claims that their statements had been misconstrued. Whilst issues of race were mentioned by one participant, most chose not to emphasise these aspects of their identity within the interviews. The accounts of female participants were more likely to picture self-harm as a means of managing distressing representations of self and this was resolved by creating new identities or through adopting strategies which enabled the individual to feel powerful. These explanations were often at odds with one another and many were utilised simultaneously. However, what these accounts had in common was a desire to justify offending behaviour though proving that the inner subjective self (or the 'I') (Mead, 1997) was intrinsically moral.

## **Chapter Five – Participant Awareness of ‘Their’ Risk Assessments and Understanding of Their Conditions**

### **Introduction**

The issue of whether those with a mental disorder pose a significant risk to others has been subject of research for over 70 years (Harris and Lurigio, 2007). Whilst some conclude that a modest connection between mental disorder and violence exists (Walsh *et al.*, 2002; Leitner *et al.*, 2006; Burke, 2010), others argue that research findings remain disparate and inconclusive (Sirotych, 2008). Although the evidence remains contested, members of the public tend to see a strong connection between mental disorder and violence nonetheless (Stuart, 2003) and this takes on particular significance with mentally disordered offenders who may also be deemed dangerous by virtue of their offending. The increasing emphasis on risk assessment within mental health policy in the UK since the 1990s can be seen to be a response to such concerns. Whilst the literature on risk and mental health is extensive, much of this focuses on the degree to which such tools might be considered effective or how risk assessments might be deployed by professional staff. Research into service users’ views is less frequent (Sullivan, 2005).

This chapter examines the third and fourth research questions set out in the introduction and methods chapter. It asks how aware mentally disordered offenders are of the way in which their risk is conceptualised by multi-disciplinary teams. In doing so it focusses on their understanding and awareness of formal risk assessments. The chapter then moves onto consider how far service users’ perceptions of their risk differs from that of their own supervising teams. This question is addressed through a comparison of the way that service users and

mental health professionals rated mental health and offending risk against a professional risk screen. The chapter goes on to discuss how far service users understood the conditions that had been given to them by the Ministry of Justice or Mental Health Review Tribunals. The chapter uses Foucault's (1991) theory of 'governmentality' to consider mentally disordered offenders' views towards 'their' risk assessments and conditions. The use of quotation marks around the word 'their' is used to indicate that whilst these assessments were written about service users, the extent to which they reflect service users' views remains unclear. Governmentality theory is used in this article as a means to analyse power relations within risk assessment processes and the extent to which service users might own such practices. Whilst research within general mental health services has indicated that service users were rarely aware of such assessment (Langan and Lindow, 2004) findings may differ in forensic settings due the particular emphasis on risk that these services have. This chapter therefore aims to examine both service users' level of awareness towards risk assessments and their views about its purpose.

### **Participant levels of awareness of risk assessment tools**

The majority of participants were aware that a risk assessment about them existed. For example, Michael laughed when asked whether his community mental health team had a risk assessment about him, and said, "they've got more than one probably". Michael went on to say that he believed staff used assessments as a means to monitor his behaviour and prevent future offending. In joking about the amount of assessments that might exist about him, Michael was indicating the importance that risk management had for professionals working with him. In line with this response, other participants showed an understanding that they had been

judged by professionals to pose an unacceptable risk to others and that their care was managed in accordance with these concerns.

Although participants generally believed that risk assessments about them existed, awareness of the content was low. The majority stated that risk assessments had not been openly shared with them. Six of the participants stated that they had never seen a risk assessment, whilst one could not remember. Participants generally stated that they had been informed of risk judgements by professionals rather than being asked to contribute towards their construction. For example,

Oliver: Yes, I heard them talking about it, saying I am going to update your risk every so often. He used to do it regularly, once a month or something like that. Steve the CPN [Community Psychiatric Nurse] who's retired now, he was in the forensic team, he used to do that.

*Jeremy: Did you ever get to see the thing he was updating?*

Oliver: He just told me basically. He said 'you're low' and we had a meeting and he would say it then in the CPA meeting.

As discussed in Chapter Two, current Government guidance implies a model in which service users are encouraged to take responsibility for risks (DOH, 2007b). Oliver's account gives a scenario in which he was informed of a judgement and given little opportunity to respond to it. The rationale underlying the 'low risk' definition was not made available and he was given limited space to respond to the judgement. Similarly, most participants felt that the processes of risk definition were rarely made explicit and few were given copies of their risk assessments. There was no common view as to which professionals held responsibility for the process and participants would sometimes confuse risk assessments with other documents such as care plans.

## User involvement within the assessment process

Participants who had been involved in risk assessment procedures showed a greater level of engagement in the assessment process. Two participants described actively contributing towards risk assessments. Their accounts differed from other participants in that they were able to outline their own role within the procedure. Ben was the only participant who described having any involvement in the construction of his initial assessment. Here he describes identifying potential risks with a psychologist:

Ben: ...[we discussed] noticing when I'm falling ill and what makes me go ill and what are the signs of when I'm feeling ill. And we drew up a plan and how we go about it if what I want to happen if I was faced with any of them signs or any signs that I was coming out. What we were going to do about it and what help I would need and what should be the outcome and should I be recalled or do I need monitoring or do I need more support. And we drew up a plan and risk assessments and such.

*Jeremy: Did most of the ideas about risk come from you do you think?*

Ben: Yes and a few from them. We agreed to disagree with theirs.

*Jeremy: You said 'we agreed to differ'. Did you feel happy with the compromises that were made?*

Ben: Yes I was quite happy with that, to respect their views as they are professionals at the end of the day and it's their job. So I have to give it to them out of respect.

Whilst power relations between participant and professionals were not viewed to be equal in this account, Ben showed a willingness to characterise some of his past behaviours as risks. This is in line with research that has found that risk issues take on an extra saliency for individuals where they are related to their everyday experience (Petts *et al.*, 2001). Whilst Ben disagreed with some professional interpretations, the difference between his views and those of his team were transparent. Although his framing of the risk events differed from professional assessments he was willing to let these perspectives co-exist on the basis that professionals were acting in his best interests.

## Risk measures and professional judgement

Six of the participants in the study referred to their risk being rated as 'low', 'medium' or 'high' within their interviews. For example, Ian referred to categories of risk within his own assessment.

*Jeremy: What would happen to the risk assessment if you didn't do any of those things [not harming himself or others]?*

Ian: It would go down in stages, they have four boxes, low, moderate, high, very high and it would go down to low.

*Jeremy: How long before it would go down to low?*

Ian: Don't know. All my life, knowing how strict these places are.

However, whilst Ian referred to his risk categorisations in probabilistic terms, this did not indicate that he believed that he was being assessed in a probabilistic manner.

The way in which the processes were described implied a system based on professional judgement. Within Ian's account, categorisation was related to the hospital system being 'strict' and risk judgements were seen to be related to behavioural standards set by staff, rather than being informed by a structured process. Similarly, Quentin talked about the way that his risk categorisation had been reduced from 'high' to 'low'. He said:

It took a long time to persuade them that I wasn't going to do what they thought I was going to do. Because I had been back and forwards to Chepston several times, I have been to the house where all the trouble started. I've been back to see my girlfriend, I've stayed weekends up there. That's why I said I get three nights [leave] a fortnight. So I stay there sometimes and there hasn't been no trouble so that's why the risk assessment 'as gone right down.

In stressing the importance of persuasion, Quentin was putting forward the view that assessments were constructed by staff and reflected values that they saw as desirable. Previous research (Godin *et al.*, 2007; Davies *et al.*, 2008) indicates that forensic service users felt that they needed to convince staff that they should no longer be labelled as a 'high-risk' through predicting and mirroring their views.

Similarly service users in my research described a process of complying with professional objectives in order to lower their risk categorisation in order to gain greater freedoms. Consequently, the process of risk reduction was viewed as an inter-relational process. Quentin's account did not suggest an acceptance of staff categorisations (he continued to dispute the staff analysis), but described a need to produce behaviours that were seen as 'low risk' by them. This suggests that service users are able to demonstrate a level of resistance to systems of regulation and that they do not always internalise the controls in the way that governmentality theory suggests.

### **Levels of agreement with risk assessments**

A number of participants were not sufficiently aware of the content of their risk assessment to make a judgement about its accuracy. Of those who felt sufficiently aware to comment, two fully agreed with what was written and five noted that they disagreed with some aspects. They had differing views about the reasons for their offending behaviour and appropriate strategies for managing their risk. Participants tended to be more positive about risk assessments where their perspectives on illness and treatment concurred with those of staff. However, the majority felt that professional perspectives framed which behaviours were seen to be appropriate and felt that that they had limited power to influence this. Coffey's (2011) research found that mental health staff tended to see social supervision as a process of risk management and reduction. Whilst service users tended not to view supervision in these terms, they did have a sense that they were people who had "got to be kept an eye on" (2011, p. 751). My research supports these findings in that participants tended to emphasise the high degree of monitoring to which they were subject. For



example, Daniel stated,

...of course it paints you, quite properly, in your worst situation, whereas you would always like to be seen in your best situation. But that's a natural thing, because of course the whole purpose of identifying risks is to enable people in, the professionals, to actually recognise improvements...

Thus risk assessment was seen by Daniel as being a means through which staff developed a baseline against which they could measure his behaviour. In referring to the staff's desire to recognise improvements, Daniel showed an awareness that his behaviour was being categorised. In this case the behaviour at the time of the offence was seen as a risk marker. This behaviour was then recorded in order to allow professionals to recognise progress. The majority of participants concurred with this view, believing that risk assessments were a means through which their behaviour was categorised and graded. Within the context of the assessment, the majority saw offending behaviour, signs of mental ill health or a combination of the two as most commonly being categorized as risk markers.

It has been suggested that service users who are detained in long stay psychiatric hospitals are conditioned into compliance (Dvoskin and Steadman 1994).

Participants in this research generally felt that they were able to voice a disagreement. In some cases they felt that this might lead professionals to check the accuracy of statements. However, whilst participants did not feel that they had to agree with the content of assessments, they did feel that they were forced to comply with assessment outcomes. This is illustrated in the following extract.

*Jeremy... did you raise the disagreement that you had, did you mention it?*

Eric: I did yeah, I did mention it, but basically I couldn't do anything about it because what the team felt was necessary, I had to go along with it.

*Jeremy: Right.*

Eric: Um, in order to stay out in the community you basically got to put up with it and just agree.

*Jeremy: OK, so you don't really think that you've got the power to disagree?*

Eric: No you haven't, you can voice an opinion but it wouldn't change anything.

In the above extract Eric notes that whilst a disagreement might be documented, he was required to comply with the results of the assessment. Eric, like several other participants, disagreed with the outcome of the assessment which suggested that he required further monitoring and supervision. This suggests that service users do not always become responsibilised subjects in the way in which governmentality theorists have suggested. Instead they may indicate a form of reluctant compliance that indicates a degree of resistance to such forms of governance. Within Eric's account disagreements were seen as unlikely to lead to a change in staff position, but rather emphasised the level of difference between parties. As a consequence of this, some participants saw risk assessments as a means by which professionals justified continued supervision.

### **Comparisons of service users' and professionals' ratings of risk**

Whilst previous research has examined the way in which service users subject to section 41 conceptualise their own risk both in hospital (Godin *et al.*, 2007; Davies *et al.*, 2008) and in the community (Coffey 2011; Coffey 2012a), there is a lack of knowledge as to how service users might rate their level of risk when presented with professional risk screens. The next section of this chapter aims to address this gap. Inferential statistics are provided to compare service users' views with those of professionals. As outlined in the methods chapter, the purpose of this approach was to assess how service user accounts of risk might compare to staff accounts when asked to narrow risk definitions in the way that is required within professional risk screens.

As noted in the methods chapter, a Kappa measure of Agreement was used which measures the level of agreement between raters taking into account the extent to which agreement might occur through chance alone (Cohen, 1968). Table 2 indicates the level of agreement between service users and professionals about the level or absence of risk. A Kappa score  $> 0.75$  was taken to indicate excellent agreement,  $0.4 - 0.75$  indicated a fair to good agreement and  $< 0.4$  was seen to represent poor agreement (Kirkwood and Sterne, 2003). Kappa scores for each participant are described in Table 2 below. Poor levels of agreement between service users and professionals were found in 14 cases and a fair to moderate level of agreement in five cases. It was not possible to conduct Kappa tests within sub-categories of risks within the risk screen (such as risk of self-harm or risk to others) as total agreement occurred between service users and staff in some cases, thus invalidating the Kappa test.

Although the level of agreement between service users and staff was generally low, service users often identified areas of risk that had not been raised by staff. The number of risks identified by service users but not by staff ranged between one and 27, with the mean number being 10.79. Service user interviewees generally identified more risks than professionals. However, this fluctuated between categories of risk.

Table 2  
Summary of service user and professional ratings of all risk categories

Participant number	Service user and professional agree about presence or absence of risk	Risk identified by service user only	Risk Identified by professional only	Kappa statistic
1	32	7	16	0.17
2	35	10	1	0.36
3	39	7	9	0.39
4	38	1	16	0.24
5	37	13	5	0.36
6	42	4	9	0.46
7	42	10	3	0.53
8	27	27	1	0.17
9	40	11	4	0.46
10	36	4	15	0.29
11	29	14	12	0.04
12	39	12	4	0.39
13	29	22	4	0.10
14	40	12	3	0.32
15	38	14	3	0.40
16	45	9	1	0.60
17	45	7	3	0.65
18	39	5	11	0.30
19	38	16	1	0.20
<b>Total</b>	719 (68.8%)	205 (19.6%)	121 (11.6%)	

When participants were asked about whether they had ever neglected themselves, most participants identified more risks than staff. The risk screen that the service users were asked to complete contained six categories of risk listed under the heading of self-neglect. In regard to these, the total amount of risks identified by all service users combined was 31, whereas the total amount of risks identified by professionals combined was 20. This trend was also present when research participants were asked about suicide and self-harm, with the majority of participants highlighting more risks than professionals. The risk screen that was presented to participants had four categories of risk listed under suicide and self-harm. The total amount of risks by all service users combined in this area was 39, whereas the total amount of risks identified by staff was 33. In contrast to the above results participants had a tendency to identify fewer risks when asked to identify whether they had ever posed a risk of harm to others. In this case, the trend was reversed

with professionals identifying more risks than service users. The risk screen that was presented to research participants contained nine items under the heading of Risk to Others. The number of risks identified by all service users combined was 87 whilst the number of risks identified by all professionals combined was 102.

These findings may be explained through reference to previous research about service user perceptions of risks. My findings are in line with research which indicates that service users use the concept of risk to understand their difficulties but tend to highlight risk to themselves; including risks associated with being treated by the mental health system (Manthorpe and Alaszewski, 2000; Godin *et al.*, 2006). The disparity between professional and service user assessment echoes differences between professionals and lay-people in other areas of risk research where lay-members have also identified more risks to themselves (Horlick-Jones, 2005). This may be explained by the tendency of lay-people to adopt wider frameworks when considering such risks (Horlick-Jones, 2005). In other words, service users may have identified more risks because they have a greater level of knowledge about their own circumstances and may not frame risk as specifically as professionals. However, this does not explain why professionals had identified more risks to others. There may be two explanations to this. First, research has indicated that professionals are highly aware of mental health inquiries which often focus on instances in which they have failed to identify risks (Warner, 2006; Passmoore and Leung, 2002). This awareness may make mental health professionals more likely to focus on risk on harm to others with research amongst different groups of nurses indicating that those who working within mental health were most likely to take a 'risk as hazard' approach (Alaszewski, 2006). Secondly, as demonstrated in the previous

chapter; mentally disordered offenders like other offenders are concerned to distance themselves from offending behavior. This can lead to a minimisation of the victims' experience and may contribute to the way in which they rate past risk to others.

### **Awareness of conditions of discharge**

Having identified the way in which research participants rated their own risk, I now move on to examine their understandings of their conditions of discharge. As outlined in the literature review, service users subject to section 41 MHA are commonly subject to conditions of discharge which can lead to recall by the MOJ if they are breached. Professionals commonly describe the conditional discharge as valuable because it is seen to encourage compliance with psychiatric and social supervision. Seen in this way, conditional discharge can be viewed as a means through which offenders are encouraged to adapt to normal social values thereby encouraging offenders to become responsible. However, research indicates that licence conditions may not be understood by offenders (Digard, 2010). Mentally disordered offenders may face extra challenges in understanding conditions as a result of difficulties experienced as part of their mental disorder. Consequently, it is necessary to explore service users' understanding of their conditions before issues of compliance can be understood.

As stated in the methods chapter, participants were asked to identify their conditions and these were then compared against the most recent categorisation of their conditions in their health and social care files. It was not possible to consider the responses of all research participants. In one case the health and social care team

were unable to locate the participant's conditions. One other participant had never been conditionally discharged and so was not considered.

Only one participant was able to identify all of her conditions correctly. Eleven were able to cite at least one condition correctly. However, most participants had a high rate of error. Analysis revealed three types of error. Firstly, participants omitted conditions. Secondly, participants identified part of a condition correctly whilst omitting other parts. Thirdly, participants completely misunderstood the substance of a condition. A summary of the way in which participants understood their conditions is given in Appendix Nine. Whilst viewing the data in this way provides a useful starting point, it is necessary to go beyond this and examine understandings of conditions across these categories. In order to do this I will highlight participants' understandings of their conditions around social and psychiatric supervision before examining cases in which conditions were misunderstood.

The conditions of all the participants in this research stated that they must comply with social and medical supervision. Four participants correctly recalled that their conditions stipulated they must meet with their social supervisor / social worker. Three participants correctly highlighted conditions stating that they needed to see their supervising psychiatrist. However, six of the participants did not recall that they were required to comply with social supervision and five did not recall that they were required to comply with psychiatric supervision. It was common for interviewees to recall that they were required to see their doctors or social workers but to omit some of the details relating to the manner of supervision. For example, in Phillip's case he recalled that he needed to go to appointments with his care team. His conditions

actually stated that he should accept treatment and supervision from his supervising psychiatrist and social supervisor. Similarly Richard stated that he should stay in touch with his doctor, whereas his conditions stipulated that he should allow access to his RC, social supervisor and care co-ordinator indicating a more intrusive form of supervision. These results indicated that some participants were unable to recall the specific requirements of supervision. However, an examination of their accounts indicated that many felt that they needed to comply with psychiatric and social supervision nonetheless. In this sense, my participants were similar to those in Coffey's (2012a) sample, in that they believed that conditions were generally constraining and that they had little scope to formally challenge them. However, what my research suggests is that participants may feel the need to outwardly comply with conditions despite not being able to recall the detail of them. This may be a representation of what Werth (2012) refers to as 'surface compliance' in which the appearance of compliance with supervising agents is seen to become more important to the supervisee than a detailed understanding of conditions.

A finding of note was that participants commonly recalled conditions relating to restrictions around drugs and alcohol. The issue of substance misuse amongst offenders has been seen as an area for concern by researchers. Longitudinal research indicates that those with a major mental illness and a substance misuse problem present the highest risk of violence toward others (McMurran, 2008). However, the extent to which these concerns are made known to service users is not known. Whyte *et al.* (2004) have suggested that whilst the majority of forensic mental health staff understand that a high proportion of mentally disordered offenders misuse drugs, many are apathetic; believing the problem to be insoluble.



This suggested level of fatalism does not apply to MOJ staff. Research by Boyd-Caine (2010) indicates that they viewed drug misuse as a factor likely to cause deterioration in mental health. These staff were also aware of reputational damage to the Minister should deterioration come about as a result of illicit drug misuse and consequently drug misuse was viewed as a matter for concern. When asked to name their conditions five participants noted that they had either been given conditions stating that they should refrain from illegal drug use and / or only take a limited amount of alcohol whilst four noted that they were required to submit to drug testing. Two recalled that they were forbidden from taking illegal drugs but did not mention that they were required to submit to random drug screening. Four completely omitted conditions relating to drug misuse and drug screening. Those that recalled drug and alcohol restrictions held a range of attitudes towards them. Eric stated that he had never used illicit drugs and that the condition had been given to him as a precautionary measure. Consequently, he was unconcerned about the addition of this condition. Other research participants stated a greater degree of ambivalence to such conditions. However, as stated in Chapter Four, research participants tended to see mental health problems and alcohol and drug misuse problems as separate issues. For this reason, many of the participants who had been given drug and alcohol conditions saw them as unjust, despite acknowledging that drug and alcohol misuse had led them to commit acts of violence in the past.

In several instances research participants completely misunderstood their conditions. In most cases this involved participants believing that they had extra conditions. For example, two participants identified that they were forbidden from taking illegal drugs and one stated that he was forbidden from drinking excessively when these were not

stipulated in their conditions. Similarly, Phillip erroneously believed that any overnight leaves needed to be agreed with his social supervisor and RC, whilst Richard thought that he needed MOJ permission if he were to have leave overnight. In three cases, research participants believed that they were required to remain in contact with certain professionals when this was not the case. The majority of these misunderstandings related to common forms of supervision under section 41, so it may be that general cultural expectations that are made of patients are absorbed and interpreted as legally enforced rather than culturally expected forms of behaviour. Quentin provided an exception to this pattern, in that he believed that explicit conditions had been placed around his behaviour relating to his offence. He had been arrested after attacking the police and had a history of being verbally abusive toward others. He believed that his conditions stated that, "If a police officer speaks to me, I have got to speak back to them in the same way" and, "if anyone speaks to me, I have to speak to them in a civil tongue". In this case it appears that general expectations by staff around appropriate forms of behaviour had been understood as legal conditions, which he was reluctantly complying with.

Although a participant might be able to recite their conditions, this did not necessarily mean that they intended to comply with them. Grace had brought a copy of her conditions to the research interview and was the only participant who had been able to identify all of her conditions correctly. Despite this, she openly stated that she chose to ignore the condition stipulating that she should not consume more than four units of alcohol a week. Her situation was unusual in that she was displaying open non-compliance with the condition. In this case she had reported her lack of compliance to the social supervisor and her health and social care notes indicated

that the MOJ had then been made aware. In this case the MOJ chose not to recall her or issue a warning and she continued to ignore the condition. Other participants reported scenarios in which they appeared not to have understood the purpose of the order in the past and had subsequently been recalled. For example, Ian noted that he had ignored conditions given to him by the MOJ stating that he must not misuse drugs. He had continued to do so and had subsequently been recalled. He stated he had not understood that he would be recalled and had believed that his care team and the MOJ would give him another chance. As a consequence of this, he maintained that he had now learnt to become compliant with the conditions. With the exception of Grace no participants described deliberately ignoring conditions. Conditions of discharge were generally experienced as very rigid. In most cases where participants described having violated their conditions they described having reported this to their teams. In these instances, the support of the community team was seen to be the best defence against recall. In this sense, approximately two thirds of the participants indicated a level of trust with their teams.

## Conclusion

Unlike the participants in Langan and Lindow's (2004) study within general mental health settings, the participants in my research were generally aware that risk assessments about them existed. However, they were often unaware of the content of these assessments and reported a low level of involvement in their construction. As noted in the previous chapter, a high proportion of service users either referred to themselves as mentally disordered in order to mitigate against the shame associated with offending (although their understanding of mental disorder often differed from that of professionals). Those who rejected notions of mental disorder entirely using

'techniques of neutralisation' (Sykes and Matza, 1957). This presented a problem for service users in relation to risk management as their conceptualisations of risk often differed from professional conceptions. Theories of power rest on notions of who is permitted to "define, describe and respond to various social behaviours" (Olafsdorrit, 2011, p. 241). Research participants tended to emphasise their lack of power in the risk assessment process. They highlighted that they were normally excluded from risk formulations which were largely seen as being framed in professional terms. As in previous research (Godin *et al.*, 2006; Godin *et al.*, 2008; Davies *et al.*, 2008; Coffey, 2012a) participants believed that staff primarily focused on issues of treatment compliance. Risk assessments were viewed as a bureaucratic tool which identified markers of risk for the benefits of professionals. However, although service users indicated that they had less power than professionals, they did not fit neatly into the model of responsibilised citizen proposed by governmentality theorists. Whilst a number of service users did seek to take responsibility for identifying and minimising health risks in line with this model; others continued to hold models of risk that differed from those who were caring for them. This was not always immediately obvious as in keeping with research elsewhere (de Swann, 1990) service users often adopted professional terms to describe their problems. However, whilst participants often used probabilistic terms (such as low, medium and high risk) they tended to view risk assessment as having been formed by professional judgment rather than by statistical measures. Service users could be seen as exhibiting what Werth (2012) refers to as 'surface compliance' to both their assessments and their conditions of discharge. That is, they often described a process where they were responding to the expectations of their supervisors without a clear understanding of risk assessments or conditions.

Ryan (2000) has suggested that mental health service users do not convey risks in the same way as staff, due to not having access to the same language. My research has shown that when presented with a risk screen, service users were more likely than professionals to identify a wider range of risks. It should be acknowledged that the empirical basis of this study has its limitations. The sample for this research was small and the statistics therefore illustrate the views of this small group rather than being straightforwardly representative of the wider population. However, my research has provided some insights into the way in which this group may perceive risk. Previous mental health research has noted that whilst service users may share professional perspectives on risk, they are more likely to identify risks from treatments (such as side effects from medication) (Manthorpe and Alaszewski, 2000; Godin *et al*, 2006). In addition to this, risk research outside of mental health, has noted that lay people may frame risk differently from 'risk experts' through adopting a wider frame of "topics, considerations and agendas" (Horlick-Jones, 2005, p. 259). The tendency of service users to identify more risks within this study may be as a result of a wider interpretation of risk, although this process is not straightforward. Risk screens pose specific questions which may not allow for the identification of all risks (the screen did not ask service users to identify side-effects from medication, for example). However, even within the risk categories presented, there was scope for service users to interpret these more widely than professionals and this may account for a level of difference. Alternatively, the difference may be due to service users holding a greater knowledge about their personal circumstances. The findings also indicate that participants tended to identify less risk to others than professionals. This might indicate a tendency for participants to convey their risk in ways which

identify them as morally good. However, it might also indicate a tendency for professionals to pay more attention to this category of risk. Greater openness at the early stages of risk assessment may lead both parties to understand one other's perspectives more. Whilst this would not resolve the issue of power inequalities between service users and staff, it would act to make differences in perspective more explicit. In doing so it may also highlight the extent to which risk assessment might act as a means by which individuals can exercise personal responsibility.

## ***Chapter Six – Service Users' Views of Social Supervision and Control***

### **Introduction**

This chapter deals with the final research question set out in the introduction, that is; what do service users subject to social supervision understand the purpose of social supervision to be and what are their feelings towards it? In doing so the chapter focusses on the element of control inherent within social supervision and how this is seen to be enacted. Related to this is the way in which participants believed that professionals framed risk. Participants' views on how such control was exercised were affected by the way they chose to define their problems. Participants fell into three main groups. The first group believed that they had suffered from a mental disorder and saw their illness as a problem that needed to be counter-balanced by particular forms of control. A second group believed that the order acted to make them internalise norms of behaviour. This group saw the conditions as forming part of this process through acting as a form of deterrence. A third group did not feel that they suffered from a mental disorder. They experienced the order as a form of labelling. I will go on to argue, that whilst participants were aware they were subject to a form of control, this was not always experienced negatively. Some participants were aware that whilst the order restricted their actions, it also had the effect of restricting the actions of professionals. These participants felt able to utilise some aspects of the order in order to plan for the future. This process was similar to Ferguson's (2001) theory of life-planning outlined in Chapter Two. The majority of participants saw the restriction order as a mechanism through which their actions might be monitored. Its operation was seen to be reliant on individuals (such as mental health professionals and MOJ officials) who were affected by wider societal

concerns. The remainder of the chapter will examine the ways in which the views of various parties were seen to affect decision-making. Participants in my research were aware that professionals were influenced by formal frameworks but were also influenced by other factors such as an awareness of how the public might view mentally disordered offenders. I will examine notions of how such views were seen to affect their care. In order to do this participants' views on defensive practice and the way that staff views might affect discharge decisions are explored. The views of the MOJ and the views of mental health staff during supervision are then examined.

### **Perspectives on the order**

All participants in the study realised that they had been placed on a section 37/41 because judges and mental health professionals believed that they had committed a serious offence. Participants had different understandings of the purpose of the section 41. Most understood that they were being dealt with within a legal framework even when they were unsure of the legal parameters. For example, in thinking about what the order meant for him Daniel recalled information given to him by his solicitor. He provided a legal definition stating,

I'm not 100% clear on it, although I did read it at the time because my solicitor made sure that I had copies of it, um, but as I understand, the section 41 is the control by the Ministry and the section 37 determines the mental state...The section 41 actually involves the Ministry of Justice and the fact I should be continually under their direction for, until there is a time possibility of absolute discharge, but not until then would I be free from control of the Ministry.

Whilst not all participants were able to give such a specific explanation as to the framework of the order, all but one was clear that they were being managed within a system that sought to control aspects of their behaviour.



## **Treatment as rehabilitation**

Participants who believed that they had offended as a result of their mental disorder often felt that the section 37/41 MHA was an appropriate means through which their risk might be reduced. For them, this was achieved through professionals monitoring symptoms of illness. In these cases a degree of security was gained through the knowledge that mental health teams were required to provide this support. For example, Adam viewed the level of support he had received under section 37/41 in positive terms. Within his account it is the order itself which provides the framework for rehabilitation and positive relations with professionals. He said,

In fact there are endless benefits, absolutely endless [of being on a section 37/41] because the main thing about mental health is you get cured, you get in the community and you try and live a nice normal life like other people do, being happy and secure you know all things like that and the 37/41 actually does that for anyone on it 'cos they're monitored. Everyone on a 37/41 is monitored by social supervisor or CPN or the doctor because of the seriousness of that illness and the seriousness of what index offence you did, so I mean there is just no end of possibilities on a 37/41.

Within this account both illness and offending are conceptualised as the problem.

Adam's account of illness has parallels with Parsons' (1951; 1975) theory of the 'sick role' in that it is accepted by Adam and others that this role exempts him from responsibility for the offence. In addition, he believed that he was subject to an expectation that he should recover. The support offered was viewed as positive because it provided the necessary stability for this recovery. Participants who adopted this position were similar to women in Gabe and Calnan's (1989) research, into women's perceptions of medical technology who actively chose to apply medical labels to themselves. This is not to say that Adam viewed all care received uncritically. For example, he complained at length about staff at a rehab hostel and

a psychiatrist there who had recalled him. When asked as to how he squared this experience with his positive view of the section he said:

There is nothing wrong with the system...If I was actually getting ill properly and they recalled me that would be like cheers all round. And then three months later if they said look back on it and see that you are ill again and I sat there saying, "yeah, yeah, I was you know", I could say nice one for bringing me in and helping me out again"...But this recall was totally different and wasn't the rules of my section. There was no broken rules, there were no rules that were ignored and even after I had been recalled I still agreed with section 37/41 as it was a personal view between me and my doctor.

Within Adam's account, the cause of the deviant behaviour in need of correction was seen to be mental illness. Adam's medical and social care records do demonstrate tension between professionals over the correct definition for his actions. His rehabilitation team had requested his recall, whilst the forensic and hospital psychiatrists viewed this action as unwarranted. What was significant for Adam was the interpretation of deviance by these parties. He objected to the way that his rehabilitation team treated him stating that they judged him according to his offence rather than his illness. In doing so he was not objecting to the form of control but to the type of deviant label being applied. Part of Adam's disagreement with his rehabilitation team centred on his perceived willingness to engage with rehabilitation activities, such as attendance at work programmes. In addition to this, concerns were expressed by the rehabilitation team about his levels of aggression. Adam complained that his rehabilitation team had not taken into account the level of sedation that he was experiencing from his medication and felt that the demands placed on him by his rehabilitation team were unreasonable. The actions of this team were contrasted against the doctor who treated him following his recall who was seen to respond more appropriately through dealing with the issue of sedation. In other words, the purpose of supervision was seen by Adam as the provision of stability through monitoring, but the effectiveness of this process was reliant on staff

framing his behaviour as socially deviant as a result of illness. Supervision was not seen to be constraining in itself and if used correctly was seen to be a tool that could enable integration and recovery. This contrasts with the view of other participants who saw supervision as a means of instilling internal discipline.

### **The order as a disciplinary control**

Service users subject to section 41 in Coffey's (2011) research commonly referred to the high degree of monitoring that they were subject to in the community. A consequence of this was that they felt constrained in their efforts to establish social identities which were at odds with professional ideologies. Participants in my research also held the view that professional perspectives limited their action. A significant proportion of participants believed that the purpose of the order was to instil and maintain a certain type of thinking. However, unlike participants in Coffey's research, one group of service users that I interviewed were more positive about both the conditioning experienced in hospital and the threat of recall. In order to explore this perspective I will outline participants' views on the form that this conditioning took, their views on the purpose of such conditioning and how recall acted to maintain this.

Participants who valued the disciplinary control offered by section 37/41 MHA gave a range of examples of forms of conditioning within forensic settings. Within these accounts service users were rewarded or punished for exhibiting certain behaviours. For example, Michael spoke of staff in a high secure hospital placing patients in

seclusion if they crossed over a painted line on the floor. In his account, patients who broke such rules were sent to an intensive care ward, which was described as a “punishment place”. This was viewed as violent, unpleasant and difficult to leave. When asked to explain the rationale for not crossing the painted lines on the floor Michael stated that the purpose was to see whether you could ‘abide by the law’ and that this would indicate to staff whether you could be trusted to abide by rules in the community. Michael believed that his level of risk had reduced as a consequence of such regimes. When asked whether he remained a risk he said,

Michael: I wouldn’t say that I’m a risk, but everyone’s got some danger inside them Jeremy.

*Jeremy: Yeah.*

Michael: It’s how you learn to deal with it. I learn how to build bridges over mine, tunnels under it, or whatever. I learn how to do all that. And like I say, I’m not the man I used to be before now. I’ve been rehabilitated. So it’s a, I’m not artificial, um, but some of my ideas was drummed into me.

Within this account rehabilitation has parallels with theories of governmentality (Gordon 1991; Dean 1997; Rose 2002), in that hospital regimes were seen as being intended to make service users internalise forms of behaviour which were viewed as acceptable by experts. As mentioned in Chapter Two, this system is seen as bringing about a change in behaviour through encouraging individuals to become responsible for their own behaviour. Michael saw himself as adopting new ideals and values which he believed helped him to navigate around risk behaviours. However, it should be noted that this system was not viewed as being distant and impersonal. This poses a challenge to Castel’s (1991) notion of governmentality which sees risk as being managed at a population level as well as Feeley and Simon’s (1992) theories which posit that rehabilitative ideals have been over-run by a generalised risk discourse. Feeley and Simon have argued that new forms of governance have given up on trying to change individuals and have instead

focussed on containing high risk populations. Whilst service users in this research did identify that their teams were concerned to reduce their risk it is important to note that these ideas ran alongside notions of rehabilitation rather than replacing them. In Michael's account this form of rehabilitation was seen to be forceful and he notes that new ideas were "drummed into me". Nonetheless, these strategies were seen as individual to him and were constructed with his needs in mind.

Whilst recall was viewed to be a negative outcome, the threat of recall was also seen to be a useful deterrent by this group. Notably, all participants in this group had suffered from drug or alcohol addiction in the past and recall was seen as a means to avoid such behaviour. Although these participants were aware that the order restricted their degree of liberty, the majority felt that the order acted as a positive deterrent and that this outweighed negative factors. In stressing the value of deterrence, these participants were presenting perspectives which echoed with themes of governmentality in that those deterrents were seen as a means to help them to internalise more socially acceptable forms of behaviour. Expert systems (in this case their conditions) were then seen as a positive means through which risk avoidance strategies could be defined (Higgs 1998). The pursuit of these strategies was viewed as being in their best interests. An exception to this was Ben, who showed a greater degree of ambivalence. Whilst noting that the order discouraged him from using illicit substances which might have harmful effects, he also noted that his level of autonomy remained low due to an incident of domestic violence with his partner which had caused the MOJ to become concerned. In this respect his

observations were similar to Dell and Ground's (1995) sample, who were often unhappy that supervision was not reduced over time.

### **The order as labelling**

A third group of service users in my research concurred with participants in Coffey's (2011; 2008) research in that supervision was seen as restricting the construction of 'normal' identities in a wholly negative way. This group of service users did not think that they suffered from a mental illness and the order was seen to limit their action in unwelcome ways. These participants were making similar claims to labelling theorists that were outlined in Chapter Two (Scheff, 1966; 1974). Three participants saw resistance to the label as being responded to through punishment. For example Francis stated,

I would be daft to argue because they would lock me up again and say I was ill like they did years ago. If I was to tell the truth and say "oh fuck off out of here I don't want you in my flat" it's like you are poisoning me which is the truth, they would then say I was getting all agitated and don't think I was very well and say I should be in hospital and stuff.

In this case, intervention from a mental health team was seen to be a form of social control in that recall was seen as likely should Francis fail to agree. Similarly, Tony believed that he was a magician but was aware that this belief was interpreted as delusional by staff and so chose not to voice it to them. What is notable is that these participants did not adopt the deviant role, as theorised by Scheff. Rather, the order was seen as a means to portray them as a particular category of person and participants learnt to pay lip-service to this in order to maintain their freedom. Rather than adopting the deviant role as envisaged by Scheff they responded with secrecy and withdrawal (as proposed by modified labelling theorists such as Link *et al.*, 1989). In addition to responding with secrecy interviewees also voiced the view that

they had suffered a 'loss of self' as a result of their diagnosis (Charmaz, 1983). In this way, the section was experienced as repressive.

Identifying the ways in which participants understood the purpose of supervision goes some way to explaining their responses to it. Whilst service users clearly saw themselves as subject to processes of control this did not mean that they felt that they had no control at all. The following section will explore ways in which service users felt that they could use the order to their own advantage.

### **Social supervision as a means of individualisation**

All but one participant was aware that they had been made subject to a legal order requiring them to engage with mental health professionals. As stated in Chapter Two, research into service users' views on supervision shows that supervision may be experienced both positively and negatively (Dell and Grounds, 1995; Riordan *et al.*, 2002; Coffey 2011; Riordan *et al.*, 2006; Boyd-Caine, 2010). Where research has identified service users' dissatisfaction it has often focussed on the intrusive nature of supervision or on the way that ordinary experiences may become medicalised (Godin *et al.*, 2006; Coffey, 2011). Whilst I do not seek to question the validity of these findings, I present alternative perspectives here which emphasise that service users may also see themselves as having a larger degree of autonomy than has previously been acknowledged.

As stated in Chapter Two, arguments about social control within social work have often focussed on whether service users are able to engage with 'individualised life planning' in which service users make informed decisions about their involvement with social care agencies (Ferguson, 2001) or whether they are subject to a form of

social control which severely limits their agency (Scourfield and Welsh, 2003). Unlike the participants in Ferguson and O' Reilly's (2001) research, service users subject to section 37/41 cannot be said to have voluntarily engaged with services, having already been made subject to an order by a judge. However, the issue of agency can be examined once they have received a conditional discharge to the community. I have noted in this chapter that service users tended to fall into one of three categories which I have outlined above. In cases where service users did not believe that they were mentally unwell the order was seen as repressive in the manner outlined by Scourfield and Welsh (2003). In these cases service users noted that they were presented with choices by their care team, but these choices were not seen to be valid as they were based on the assumption that they were mentally ill. However, a number of service users who did not fall into this category felt that they had some control over the order.

Service users who are subject to a conditional discharge may be given an absolute discharge by either the Ministry of Justice or a Mental Health Review Tribunal. This group of service users are not given an automatic tribunal if they do not apply for one themselves. The service users who felt a degree of agency over their section were aware of this and felt that they had a good chance of being discharged in the near future. In these cases the service users felt able to utilise the order in order to control the actions of their teams. Two participants in the study had been unable to access mental health support prior to being detained under the section. For these participants the order had the welcome effect of guaranteeing continued support. Both Adam and Grace recounted that their team had encouraged them to apply for



MHRTs in order that they could receive an absolute discharge. Both had approached these appeals from their teams with a degree of caution. Grace said:

... they [mental health team] said it's very unlikely I'll get off on the first one [Mental Health Review Tribunal] but we will go for it anyway. And I think I will tell them when I'm ready. At the moment everything is great, I'm getting the support. If I do go to the tribunal and get off my section I will lose all that support and there is a higher risk of me re-offending without that support if you know what I mean.

In some respects Grace is similar to some of the service users in Dell and Grounds' study (1995) in that she wished to maintain contact with her supervisors once supervision had ended. However, she was sceptical that such support would be offered should the order be withdrawn and it was seen as guaranteeing such support. Grace was aware that her team wanted her to be discharged from the section but felt that she required services and was able to refuse to apply for a tribunal as a means of preventing this. In doing so she was able to exercise a degree of control over staff. Similarly, Michael stated that he wished to remain on the order for the time being both because it acted as a deterrent from drug taking and because it guaranteed that he would be placed in supported accommodation (which he felt prevented him from falling in with bad company). He stated that he wished to be rehoused near to his family and noted that social supervision would make sure that appropriate accommodation was found. He noted that presence of the order would require a new social supervisor to be appointed once he had moved. Whilst he hoped that the order would be lifted eventually he had made a conscious decision to delay an appeal until he had been rehoused. This type of engagement with the order can be seen as a form of 'individualised life planning' (Fegurson, 2001). In these cases service users felt able to utilise the order in order to minimise their own risks. These interviewees were not naïve to the possibility that a

supervisor might order their recall or that they might have to work with a supervisor who they did not get on with. However, they were aware that as well as constraining their actions, the order also acted to constrain the actions of staff and that it could be used tactically in this way.

### **Participants' perspectives on the views of professionals and the wider public**

In this section I will argue that whilst participants recognised that the order provided a certain type of structure, they were also aware that the order was administered by workers at the MOJ and by mental health professionals. As we have seen, individuals held a range of views as to whether the order constrained or enabled them. However, they were also aware that the willingness of staff to take positive risks was affected by wider public perceptions of mental disorder. Whilst they were aware that their care was influenced by law and policy, they often spoke of the effects of individual practitioners in influencing the direction that their care took. Furthermore, they were aware of the emotional dynamics between their supervisors and them. I will outline each of these themes individually. For the sake of clarity, I will begin by outlining defensive practices that participants identified all decision makers as being subject to. I will then go on to examine the way in which participants discussed the emotional aspects of these relationships.

## **Participants' views on public perceptions of mentally disordered offenders**

As outlined in Chapter Five, participants were aware that risk was seen as a significant issue within forensic mental health care, even where they had not seen copies of their risk assessment. Participants rarely felt that they posed a risk to others in the present but were often aware that they remained subject to a significant degree of control. When thinking about why this was the case, a number of participants referred to public assumptions about mental illness. Numerous international research studies into public attitudes around mental disorder bear this view out and show that the public are often poorly informed (Angermeyer and Dietrich, 2006). Media images of mental disorder are predominantly negative (Philo *et al.*, 1994; Lawrie, 2000), although the media in the UK are no more likely to report homicides by the mentally ill than by perpetrators without a mental illness (Kalucy *et al.*, 2011). However, the tone of reporting may have an effect on public perceptions (Kalucy *et al.*, 2011). Research in the UK found that when presented with the statement 'the public should be better protected from people with mental health problems' 25% replied positively in Scotland (Scottish Executive, 2004) and 34% in Northern Ireland (Health Promotion Agency for Northern Ireland, 2006) (no research of this nature currently exists in England and Wales). Participants tended to feel that such assumptions about mental illness were important when considering the effect on their release. Significantly though, they generally referred to their status as people suffering from a mental illness rather than their status as offenders. In doing so, they often drew on notions promoted by some mental health campaigners who argue that the public is badly informed and may stigmatise mental health service users as a consequence (Jorm, 2000). Participants believed that the public would be likely to view them as dangerous and unpredictable and that such public

perceptions may then alter decisions relating to their discharge and subsequent care. Such perceptions were largely viewed as unjustified as most believed that they had recovered from their mental disorder.

### **Defensive practice by professionals**

Within the risk society thesis, increased concerns with risk have led both to a lack of trust in professionals (Beck, 1992) as well as a prioritisation of the need for protection against hazards and security (Munro, 2004). The centrality of hazards are emphasised in such documents as mental health homicide inquiries which create 'causal networks of risk' (Warner, 2006, p. 230) between people, places and things as a result of the incident which is being examined. This may then alter the nature of professional practice. As Stanford (2010) points out, when thinking about the management of risk, practitioners may be aware not only of the participants' risk to others, but of the reputational risk to themselves. Participants in my research felt that such concerns were likely to affect all parties who needed to make decisions about them including, judges, tribunal members, staff at the MOJ and mental health professionals. Participants were made aware of such considerations in a number of ways. For example, Eric noted that a judge at his tribunal was unwilling to grant him an absolute discharge. He stated that although his care team supported an absolute discharge, the judge was unwilling to accept this and said,

...'if I was to give you an absolute discharge', um, because of the previous two fires", um he said, 'I don't want the press knocking on my door...when you set somebody's house on fire'.

Similarly, a number of participants felt that elements of MOJ decision-making were affected by views of the public and therefore had a political dimension to them. This

view is supported by research by Boyd-Caine (2010) that indicates that MOJ workers are concerned with both risk management and the affect that a decision may have on public confidence in the MOJ. Whilst some participants were of the view that MOJ staff would consider such factors, their perceptions of judgements in which public opinion was considered were less positive and they tended to view such decisions as unjust. For example, Daniel, had committed an offence that had been reported in the press nationally. He had wanted to move to an area that was closer to his family but was also closer to the victim. He was informed by his social supervisor that his case worker at the MOJ had made strong representations on his behalf but that the victim had appealed to the Secretary of State who had ruled against him. When speaking of this, he said,

...the other thing, that of course affects one's situation, is the political light in which politicians wish to be viewed when elections are actually imminent. So you find yourself being a bit of a political football, which is unfair really.

As discussed in Chapter Four participants in the research most commonly referred to a recovery from mental ill health as the reason for their reduced risk status. These participants tended to see illness as having provided a moral justification for their actions. An effect of framing the offence in this way was that public confidence in the system was rarely viewed as relevant. Where the views of the public were cited, they tended to be framed as prejudiced or ill-informed.

Previous research has found that both social workers (Warner, 2006) and psychiatrists (Passmoor and Leung, 2002) fear the effects of mental health inquiries and report that the findings of these bodies encourage them to take more defensive decisions. Research participants were aware that social supervisors and psychiatrists may be influenced by tribunals or inquiries, although defensiveness on

their part appeared to be judged more sympathetically than that of workers at the MOJ. For example, Phillip notes that,

I think they [mental health team] probably feel a bit burdened by it [supervision] to tell you the truth. I think they think well we've got this person, we can't get rid of him, we're totally responsible for this person. It's like Clive [social supervisor] said to me, he said, 'don't mess it up. It's on my life'.

Within such accounts risk considerations were not seen to incapacitate staff, although they were seen to weigh heavily on their minds which might then cause them to proceed more cautiously than they might otherwise have done.

### **The effect of staff views on discharge decisions**

When speaking about how they came to be admitted to and discharged from hospital under section 41, a minority of participants felt professional views were unimportant. In these accounts judges and mental health professionals were seen as administrators of a set process. For example, Henry felt that a section 41 was applied, "to anyone who assaults". However, in the majority of cases participants felt that the legal processes were informed by the opinions of judges, doctors and nurses. Whilst discharge from a section 37/41 MHA can be granted by the Secretary of State following a request from a Responsible Clinician, the majority of discharges are granted by a MHRT. The most recent figures indicate that in 2008, the Secretary of State granted 78 conditional discharges, whilst the tribunal service granted 351 (MOJ, 2009). Although the MHRT is an independent legal body which reviews the legality of detention, participants were generally of the view that they were unlikely to achieve discharge without the support of mental health staff. This view seems to be supported by the research evidence which indicated that those patients who agreed

with staff perspectives were more likely to be discharged by tribunals (Freckleton, 2003). In cases where participants disagreed with staff views, then the tribunal process became adversarial. Previous research has found that tribunals are often experienced as intimidating by mental health service users and that this can lead to service users becoming cynical about how just the process is (Sydeman *et al.*, 1997). This is illustrated in Lamal's description of his MHRT hearing. He says,

...these judges, if I could talk to them one to one like you and me are having now I could make more sense of them. But the doctors try and say, "he's taking drugs, because he told me he smoked cocaine". And the nurse comes up and says, and she goes, "oh, he told me he goes gambling"...I had to wait for all of them to do their bits of conversation and then when I come to the end that panel was tired and they said, "let's have a break"...

Within this excerpt, professional views of the participant were seen to be dominant in constructing assessments of risk. Lamal experienced his own views as being seen as less significant than professional interpretations of his behaviour and were heard at a point where he had little energy to respond. Although negative views of the tribunal process were not common, participants generally felt that staff perceptions of risk were an important part of discharge decisions. Perception of risk was seen to be framed around the medical model and subsequently the issue of 'insight' (whether or not a person believes they have a mental disorder) became important.

Research participants were aware that the views of different mental health professionals might differ. Differences in risk perceptions between legal and mental health professionals were noted by several participants. For example, Eric, who had a history of arson, recounted that whilst the police had not viewed a fire setting incident as a matter of concern, his supervising psychiatrist and social supervisor had interpreted this differently. So whilst not all professional groups were seen to

adopt explanations focussing on a person's mental health, participants felt that they were subject to this model. Such assessments were seen as being operated both formally and informally. Discharge was seen as substantially more difficult to achieve where participants did not concur with assessments based around mental health considerations. In cases where participants did not agree with their team's perspective, they found discharge more difficult to negotiate. For example, Phillip agreed that he had suffered from depression, but rejected his team's belief that he had been delusional. He noted that his discharge was delayed because he would not agree with their interpretation saying:

That was the issue with me, insight basically. That's what they were saying, that I didn't have any insight.

Whilst his team was eventually willing to support his discharge, the difference of opinion led to concerns by staff which needed to be resolved through further psychological assessment.

### **The responses of different parties throughout supervision**

On receiving a conditional discharge from hospital, service users subject to section 41 continue to receive extensive monitoring in the community. The move from hospital to community is often not a one-step process and may include smaller steps, including residential care or other forms of supported living (Coffey, 2011). Although less overt, service users continue to be controlled through organised processes (Cohen, 1985). Armstrong (1995) has argued that a shift in emphasis from hospital to community medicine has placed a greater emphasis on contingency. In other words concern has broadened from a focus on the symptoms of disease to risk factors pointing to disease potential. The emphasis on risk potential is



particularly relevant to service users subject to conditional discharge as they are subject to recall under section 42 (3) of the MHA 1983. Although service users may enjoy a greater degree of autonomy in the community, research has indicated that the threat of recall weighs heavily on individuals (Coffey 2011; Dell and Grounds, 1995) with recall being seen to be decided primarily by the MOJ with other parties having a degree of influence over such decisions.

### **The views of the Ministry of Justice**

Whilst it is the Secretary of State who is ultimately accountable for restricted patients, it is civil servants in the MOJ's Mental Health Unit who make decisions on a daily basis. In a small minority of cases, participants were unaware that their team was reporting to the MOJ or could not understand the purpose of this, believing that their doctor held the same powers of recall as under civil section (see Chapter One for an explanation of these processes). However, the majority of participants were aware that the MOJ had a significant role in their care and that mental health professionals were reporting to them. Within these accounts, the MOJ was seen to be making judgements about the appropriateness of their behaviour. For example, Henry stated that the role of the MOJ is to "make sure that I don't get into any mischief". The vast majority of participants were aware that the MOJ had the power to recall them back to hospital in certain instances.

As stated in Chapter Two, mental health professionals in previous research have complained that the MOJ has a tendency to be over cautious and over-restrictive. In these cases, mental health practitioners view MOJ as negatively affecting the interests of service users. In some cases mental health professionals see the MOJ

as working against the 'least restrictive' principles of the MHA (Boyd-Caine, 2010). However, workers at the MOJ Mental Health Unit tend to see their cautious approach as valuable in maintaining public safety and public confidence in the system (Boyd-Caine, 2010). Participants in my research generally saw the role of the MOJ as to maintain public safety, although the manner in which this was seen as being achieved varied. For some, workers in the Mental Health Unit were seen as primarily processing decisions. Within these accounts, workers were seen as lacking the ability to make professional judgements

For example, Sally said,

They are all clowns aren't they? Lee [social supervisor] said that they generally just accept what they say from here [social supervisor and supervising psychiatrist] but they have got the power to override overall

Participants who held such views tended to see the MOJ as being dependent on professional judgement. Whilst they had power to over-ride professional decisions, there was no clear view as to when or why they might do so. So, whilst the MOJ was seen to be concerned with issues of risk and protection in these cases, the mechanisms by which this was achieved were somewhat hazy.

Other participants felt that the MOJ was more actively involved in their care.

Participants who put forward these views also tended to emphasise the agency's role in maintaining public safety. What was surprising was that a number of participants portrayed the agency as benevolent in nature. For example, Daniel talked about feeling supported by his caseworker. He discussed his caseworker's reaction to pressure by the victims to extend the areas from which he could be excluded.

...she [MOJ caseworker] has very strong feelings that I'm progressing well and that I should be left to carry on my life as normal. The least amount of interference the better. So I was quite, I was quite warmly affected by that because it gave a human touch to an office which you would consider, perhaps

not to have that much sort of emotion...So they're not sort of cold heartless people. They are ordinary, warm hearted people who see their job as a very important job and actually keep very closely involved with what happens to individuals.

Within this interview, Daniel saw his case worker at the MOJ as advocating for him in line with his best interests. Although greater restrictions were imposed, he differentiated between the role of the individual case workers at the Mental Health Unit and their managers, whom he saw as more politically motivated. The notion of the MOJ acting in the interest of service users was also put forward by other participants who saw the agency as guaranteeing their rights. Within these accounts the MOJ was viewed as the agency with the ultimate authority. As such it was seen to have influence over lesser authorities, such as participants' mental health teams or housing providers. Michael saw the MOJ as guaranteeing that his rights were upheld on recall. He says,

I've been under the Home Office from '92 and they can be, and it's eighteen years so they can build up a picture of you without actually seeing you and what they've read about you every month, every three months...They can tell what, if, if you're, if you're getting better, if you're getting ill or if you're stable all the time. Well, I'm stable all the time.

In his account, the MOJ are seen as having a greater understanding of his needs than individual mental health practitioners. Whilst reports provided to the MOJ were submitted by mental health practitioners and case workers from the MOJ had not met him personally, he was of the view that the weight of reports allowed the MOJ to make a judgement that had greater authority than mental health team practitioners. In addition to this the workers at the MOJ were seen to uphold his right above those of the community mental health team, who Michael viewed as wishing to stamp their authority onto him in acceptable ways.

## **The views of mental health staff during supervision**

Participants in my research were aware that staff assessments of risk by mental health professionals (either formal or informal) were a key part of them remaining in the community. In common with Coffey's (2008) sample, they had a strong sense that staff were continually monitoring and evaluating them. The majority felt that staff assessment of risk had a significant effect on the care that they received and had a variety of views about how this affected staff action. Staff concerns were understood to be broad. For example, when he was asked what kind of behaviours staff might view as risky, Phillip stated,

Taking drugs. I suppose risk is anything that could make you relapse into mental illness and anything that could cause you to be violent or do anything that is wrong.

Although risk was seen to be broadly defined, there were a number of behaviours that were commonly cited as being seen as danger signals by professionals. These included not taking prescribed medications, taking illegal drugs, drinking excessively, mixing with the wrong sort of people or being unoccupied for long periods of time. Medical perspectives were seen to predominate. Although a range of risk factors were seen to be a cause for concern, these concerns were usually viewed in relation to their mental health. For example, Henry noted that his history of assaults led to the imposition of the order. He noted that his conditions required him to take medication and to limit his alcohol intake. This was seen when he said that staff were worried about him

Going back on the slippery down, they might say that I am going back to the illness, the illness is taking control.

This quote illustrates a common theme amongst participants. Although they felt that staff worried about a range of factors, relapse into mental illness was seen to be the

primary concern. Thus, factors such as illicit drug misuse, excessive drinking or lack of occupation were seen to be problematic because they might destabilise mental health. In identifying such behaviours as a cause for concern, participants were highlighting their team's concern with pre-cursors to mental disorder. Staff concerns with offending behaviour in itself were seen to be less dominant. Research into social workers' approach to risk decision-making indicates that notions of moral worth can be pivotal in deciding whether to act defensively or to promote positive risk taking (Stanford, 2010). However, participants in my research viewed staff as being concerned with behaviours related to mental disorder rather than being focussed on the moral issues of offending. In this way, the patient's moral obligation to get well (Parsons 1951; 1975) were seen to pre-dominate amongst staff over wider issues of offending behaviour.

Participants largely felt that social supervisors and supervising psychiatrists applied rules in a similar fashion. This similarity might be explained by the way in which both professional groups approach mentally disordered offenders generally. Research by Davies *et al.* (2006) notes that forensic mental health staff of different disciplines tended to frame risk in different ways. However, other research has found that whilst different professionals held differing views about the nature of mental disorder, social workers and psychiatrists tended not to disagree where cases were seen as 'clear cut' (Colombo *et al.*, 2003). It might be that given the severity of the circumstances leading to admission, disagreements about the nature of the disorder were less common than might have been the case in civil mental health settings. Participants in my research were able to differentiate between professional roles in a minority of cases. For example, seven participants felt that their social supervisors were

concerned with occupational activities, housing and financial needs whilst supervising psychiatrists were seen as primarily concerned with mental state and medication review. However, they generally felt that both would supervise them in a manner prioritising public safety. In cases where doubt existed over their level of safety, the majority felt that staff would ask for them to be recalled. For example, Eric noted that,

Oh, he [supervising psychiatrist] would make sure that I was in the safest place possible and if he wanted to, and he actually determined that I was mentally unstable or not managing myself properly he would undoubtedly ask for me to be recalled to hospital but of course nobody wants that to happen.

Although participants in my research felt that professionals would act in order to maintain public safety, the manner in which this might be conducted was seen to vary widely between individual professionals. Participants in my research held a range of views about supervision, which ranged between seeing it as helpful or overly intrusive. What was notable was the way in which participants referred to both the function of staff and their personalities. Whilst policy may guide professionals to focus their practice around risk considerations, practitioners may choose to focus more on relational aspects of supervision (Udwudike, 2011). For example, whilst Michael was aware that staff were required to supervise him, he also noted that different individuals interpreted this in a variety of ways. He contrasted his previous “good” social supervisor with his current supervisor, who he characterised as, “a bit too strict”. Similarly, he compared the approaches of various psychiatrists involved in his care. In this case he noted that his previous psychiatrist’s attitude was, “to stamp down his authority straight away”. Thus different dynamics were seen to be set in motion by the way various supervisors interpreted their roles.

Participants referred to supervision as an emotional interaction. Such emotions might hinder or assist the supervision process. Neil stated that his relationship with his supervisors was one characterised by trust. He maintained that although the supervision framework prescribed the limits of acceptable behaviour, his team felt that they did not need to enforce this because they could see what type of person that he was. He noted that his supervisors asked him about things that were important to him. He said,

...he [social supervisor] asks me questions, like, you know, 'what have you been doing this week'...You know, and, 'have you heard from your family, you went to see them, how did that go?'. So it's not monitoring, it's just, I feel like I'm befriended...Before I came out, before I was discharged I used to think that they would do this and check your medication and do all that stuff, but they don't. They observe me, but they don't monitor me.

In this case the relationship was seen to take precedence over more intrusive forms of supervision. The process of supervision was seen to be acceptable to the participant because it was built around notions of trust. Thus, the participant's interpretation of staff intentions can have an effect on the way in which supervision is experienced. However, this might also be experienced in negative ways. For example, Sally noted that she found her supervising psychiatrist difficult to talk to stating,

I don't like Dr. Neill, he reminds me a bit of Simon Cowell [reality TV judge], a scary man...

In this case, Sally was noting that her emotional response to doctors was different to that of her social supervisor. Although she was aware that both were required to make judgements about her to the MOJ she was aware that her emotional response to her doctor negatively affected her responses to him. Emotional responses may therefore differ widely. Participants were aware that differing nature of these

interactions might affect the nature of supervision and consequently the course that it might take.

## Conclusion

This chapter has addressed the question of what research participants felt the purpose of supervision to be and their attitude toward it. Participants in this research all fell within Cohen's (2005) narrow definition of social control in that they were subject to organised supervision which had been arranged following specific concerns identified by state agencies. However, when thinking about the purpose of supervision and the way in which it operated, interviewees often drew attention to broader understandings of social control such as the expectations of their functioning within the sick role (Parsons, 1951). As argued in Chapter Four, illness was often used as a form of mitigation and through drawing attention to such informal social controls, some participants sought to frame supervision as supportive rather than coercive. In other cases supervision was presented as a means through which behaviour might be monitored and this was often experienced as supportive. Although the minimisation of risk was seen to be a central purpose of supervision, this focus on risk was not seen to override rehabilitative objectives as Feeley and Simon (1992) have suggested. Those who experienced supervision as supportive often reported positively on the way that interventions had improved their lives. In these instances risk objectives were seen to work alongside rehabilitative objectives rather than having replaced them. However, in cases where participants did not believe that they suffered from a mental disorder, supervision was experienced as coercive.



This chapter has added to the understanding of the way that power was understood by service users. In line with a number of previous research studies (Godin *et al.*, 2006; Coffey, 2011), my research has highlighted instances in which service users felt disempowered by supervision. I have argued that those who did not accept that they had a mental illness felt that they had been labelled. However, even in these cases participants showed a level of resistance. Rather than exhibiting 'secondary deviance' by adopting given labels as Scheff (1966, 1974) has suggested those with a mental illness are forced to do, interviewees tended to respond by withholding certain information from mental health staff in line with modified labelling theory (Link *et al.*, 1989). Although many of the service users that I interviewed highlighted the limited power that they possessed this was not the experience of all. Some service users showed awareness that social supervision acted to limit staff responses and believed that the order provided them with the means to reflexively plan their lives in line with Ferguson's theory (2001). Finally, it should be noted that service users held complex views about the manner in which power was exercised. Although social supervisors and supervising psychiatrists were seen to co-ordinate supervision, there was no fixed view amongst participants as to who was 'in power'. Rather, power was seen to be influenced by a mixture of professional ideology, public opinion and professional responses to public views. Risk was seen to be a dominant concern by professionals. Whilst staff were seen to predominantly focus on a medical model of risk they were also seen to be concerned by the risk to their own reputation although these practices were seen to be further mediated by the individual characteristics of supervisors.

## ***Chapter Seven – Conclusion***

### **Introduction**

This chapter begins with a summary of the research findings. I then go on to draw the findings together in the following ways. First, there is a discussion of the theoretical ideas that have been used in this research to understand service users' views of risk. In this section I show how my findings add to the body of existing research. Second, areas for future research are outlined. Finally I discuss the implications that my findings have for social work practice and I present a view as to how social workers might practice ethically within this area.

### **Summary of research findings**

Chapter Four addressed the question of how service users viewed their own offending behaviour and the degree to which this impacted on their identity. The chapter also addressed the issue of whether this group believed that they posed a risk in the present or had posed a risk in the past. In posing these questions, the chapter focussed on the identities of the mentally disordered offenders. The service users in this research were concerned to present themselves as moral individuals. This was achieved through emphasising the context of their offending. It occurred alongside a tendency by most to minimise descriptions of the offending behaviour which had led to the order being imposed. The majority of participants cited mental illness as the predominant explanation for their offending. In doing so, they often referred to statements by doctors and legal professionals in order to give their accounts greater weight. Other explanations were also provided for the offending behaviour with some of these running alongside illness explanations. Research participants cited the influence of illegal drugs on their behaviour, spoke of cultural

factors or saw the course of their life as being influenced by fate. Some assessed their level of risk through comparing themselves to other offenders. Although the majority of research participants saw themselves as having a mental illness, these accounts sometimes differed from those documented in their mental health records. Many did not accept professional explanations wholesale and some rejected mental illness explanations altogether. This last group emphasised their moral worth through accounts which sought to show that their behaviour had been wrongly identified as deviant.

Chapter Five addressed the question of how far service users were aware of the way that risk was conceptualised by their multi-disciplinary teams. It then moved on to examine how far service users' perceptions of risk varied from that of their supervising teams. Unlike mental health service users in general mental health settings in Langan and Lindow's study (2004), the service users I interviewed were aware that staff were monitoring their level of risk. Most thought a risk assessment about them existed but were vague as to what this might consist of. Whilst some participants had been informed of their level of risk by staff, most stated that they had not been given copies of assessments. Risk assessment tools were largely seen as a means through which professionals monitored and measured their behaviour. Of those who felt able to comment on the content of assessments, most felt able to voice disagreements. However, although they felt that this might lead staff to check disputed facts, it was not felt that this would change the overall direction of the risk management strategy. In cases where service users had been involved in constructing or reviewing risk assessment documents, they showed a greater level of engagement with the process. Whilst this did not always equal an

agreement between service user and staff, it did allow a greater degree of transparency. When asked to complete a risk screen participants generally identified more risks than professionals. However, whilst they noted a greater level of risk to themselves and environmental risks than professionals did, this pattern was reversed in the case of risks to others.

Chapter Five also detailed participants' understanding of their conditions. Research findings revealed that the majority of participants were unable to cite their conditions correctly. Whilst many were able to recall that they were required to meet with their social supervisors and supervising psychiatrists, it was uncommon for participants to remember the details of the supervision requirements. Conditions relating to restrictions around drug and alcohol misuse were recalled by a significant number, although this did not apply to all participants. Research participants commonly misunderstood conditions. In these cases they either misinterpreted the intention of the condition entirely or falsely believed that they needed to comply with extra conditions. The process of compliance with conditions was complex. An understanding of conditions did not necessarily lead to compliance, with one service user stating that she openly ignored a condition. However, the majority avoided open confrontation and opted to demonstrate a level of compliance, even in cases where conditions were not fully understood.

Chapter Six addressed the question of what service users understood the purpose of social supervision to be and their feelings toward it. Whilst all participants felt that they were subject to forms of control through section 41 MHA, their views about this varied. Service users fell within three main groups. The first felt that the order

provided an appropriate means through which their mental illness was highlighted and treated. This group felt that the order kept a focus on their illness and in doing so gave them the means through which to engage with society. A second group felt that the order acted to help them learn and internalise behavioural norms. Although participants in this group did not discount mental illness explanations, the role of professionals in shaping and enforcing appropriate behaviour was given greater emphasis. A third group felt that the order acted to label them as mentally ill in a way that was experienced as oppressive. Whilst participants largely believed that the order constrained them in some way, some were also aware that the order had the effect of prescribing professional responses. These participants felt that they could utilise the order, in a limited way, towards their own ends. This group understood that whilst section 41 MHA gave professionals certain powers, these powers were interpreted by individuals and agencies which were in turn influenced by wider societal views about mentally disordered offenders. Professionals were seen to hold similar concerns which emphasised the risk that service users might pose to themselves or others. These understandings of risk were seen to be predominantly focussed around the medical model. However, professionals were also seen to be concerned about the risks to their own reputation and this was also seen as having an impact on the way that care was provided.

### Theoretical insights

Understandings of service user perspectives within forensic mental health care are still at a very early stage. My research comes from a sociological perspective and has made some new contributions to the research base which I will outline below.

Before doing so, I will revisit the starting point for my research. Whilst Davies *et al.*'s

(2006) work has examined the views of different parties toward risk; my research is the first to focus specifically on service user perceptions of risk assessment and management strategies. Coffey's (2011; 2012a) research shows that users tend to focus on the ordinary aspects of their identity. In deciding to study this area I acknowledge that service users may not prioritise risk categorisations when forming their identity. However, I felt that it was important to focus on their perception of risk for a number of reasons. Some social theorists have argued that risk has replaced need as a key organising principle in late modern society (Beck, 1992; Giddens, 1998). Such theoretical notions need to be looked at carefully. Whilst risk is a dominant theme within late-modern society, research evidence suggests that notions of risk may be interpreted in different ways by different groups of people (Horlick-Jones, 2005). Mentally disordered offenders are commonly viewed as a 'high risk' group by mental health professionals and professional research has been concerned to find ways to measure and evaluate risk factors. Risk is often presented in the literature as a taken for granted notion and user views are rarely considered. I therefore thought that it was important to ask mentally disordered offenders how they perceived aspects of their own identities which had been identified as high risk by others. In doing so, I acknowledge that I have been asking service users to engage with professional concerns rather than providing them with a blank canvas to map out issues of primary importance to them. However, given the increasing professional focus on identifying and managing risk (Feeley and Simon, 1992) I felt that it was important to gain an understanding of both their own perceptions of risk and of the risk management frameworks that they were subject to.

My research has furthered understanding of the way that service users subject to section 37/41 MHA construct their identities. Participants in my research were similar to those in Coffey's (Coffey 2011; Coffey 2012a) study in that they chose to highlight the non-offending part of their identities. Although I asked research participants to focus specifically on events that had led them to being placed on a section 37/41 MHA, the majority chose to give accounts which minimised their offending behaviour. In this respect my research supports Presser's (2004) account of offenders as people who are concerned to present themselves as moral beings. As Webb and Harris (1999) have argued, mentally disordered offenders may be judged to be doubly stigmatised in that they are identified as both being offenders and as mentally disordered. However, I have demonstrated in this research that service users negotiate between stigmatised identities in order to reduce their stigma overall. The majority of service users who I interviewed chose to identify themselves as someone who was mentally ill rather than someone who was an offender. In this respect they were similar to Coffey's sample in that they used illness as a form of mitigation for their offending behaviour. There were also parallels with Coffey's (2012a) and Hudson's (2005) research samples in that both compared themselves to other offenders in order to signal that their own risk status was comparatively low. However, I depart from Coffey's findings in a number of respects. A number of research participants in my study wholly rejected medical labels. In understanding how this group continued to see themselves as moral I have applied theories relating to techniques of neutralisation (Sykes and Matza, 1957). As I have already argued, rather than simply accepting or rejecting medical labels, service users tend to use a range of explanations to prove their moral worth. In addition to this I have applied notions of risk as fate (Kemshall, 2002) to understand how some service users

understood the notion of risk in their own lives. I have also been able to refer to theories relating to humour to this group to understand how professional understandings of risk may be minimised (Emerson, 1973).

My research has also drew upon governmentality theories in order to explore the way in which risk assessment practice was understood by service users (Rose 1999; Castel, 1991; Foucault, 1991). Governmentality theorists have highlighted the way in which individuals are compelled to manage their own risk, with those who are judged to be unwilling or unable to do so becoming the focus of welfare agencies. This theory holds that individuals are encouraged to make prudential choices through referring to expert knowledge. My research has examined the extent to which risk assessment have acted as a means through which offenders accepted responsibility for minimising their risk to others. I have argued that whilst government guidance (DOH, 2007b) suggests that service users should use risk assessments to minimise their own risk, the majority of participants were unaware of the contents of their assessments. This indicated that risk assessments were rarely used by service users as a means of lowering their risks. Researchers have differed in their views of how service users conceptualise risk. Ryan (2000) argues that mental health service users do not refer to risk because they do not have access to the same language as professionals. Others have argued that whilst service users do use the concept of risk to conceptualise their difficulties they focus on different aspects of risk than staff (Manthorpe and Alaszewski 2000; Godin *et al.*, 2006). My research has found that when presented with professional risk categorisations, service users had a tendency to identify more risks than staff. However, research participants identified less risk to others than did staff. This would again support the



theories that argue that individuals are concerned to present themselves in a moral light or that they are more concerned with their own welfare to that of others.

Lastly, I have referred to theories of social control to understand the way in which service users understood the order itself. Social control theorists have argued that mentally ill individuals are encouraged to comply to social norms through adopting the sick role (Parsons, 1951), through processes of labelling (Scheff, 1966) or through being taught to self govern risk (Foucault, 1991; Rose, 2002). When thinking of the purpose of the order, service users drew on a wide range of understandings. Firstly, participants saw the order as enforcing treatment. I have argued that participant responses might be understood through reference to Parsons' (1951) theory of the sick role. That is, sickness was seen as a deviant identity and that integration might be brought about by successful treatment. In these cases, the order was seen as a means through which this process might be monitored and enforced. Other participants referred to the way that the order provided a structure through which to instil and maintain a certain type of thinking as Rose has argued (2002; 2000; 1999). Although I have argued that risk assessments were not seen as a means through which service users monitored their behaviour, my research indicates that the supervision process generally can be seen to be a means through which some service users saw themselves as being made responsible for the management of risk. However, rather than management being seen as impersonal and based on universal risk objectives as some academics have suggested (Castel, 1991; Feeley and Simon, 1992), service users often saw themselves as the recipients of personalised services which were as much about rehabilitation as the management of risk. Thirdly, I have argued that in cases where

service users believed that absolute discharge might be achieved social supervision was sometimes seen as a means through which individuals might plan and manage their lives as Ferguson (2001) has proposed in relation to mothers engaging with child protection services. Lastly, I have highlighted how others have viewed the order as a means of negative social control akin to labelling, although I have argued that the effect of labelling is secrecy on the part of the service user as proposed by modified labelling theorists (Link *et al.*, 1989) rather than the process of secondary deviance proposed by Scheff (1966; 1974). In making these arguments I have aimed to highlight the complexity of service user responses noting that users do not adopt a unanimous view as to the nature of social supervision.

### **Areas for future research**

Mentally disordered offenders are a group of people who are feared by the public and are consequently the focus of professional concern. They attract high levels of resources, compared to mental health users who are non-offenders. Despite this, they remain a relatively under-researched group. In this next section I suggest areas for future research, focussing firstly on forensic mental health settings, secondly on general mental health settings and thirdly on how levels of risk between forensic and general mental health service users might be perceived comparatively.

I will begin my discussion of future research in forensic settings by focussing on ways in which understanding of the views of service users subject to section 37/41 MHA towards risk might be extended. As stated above, my research has looked at the way that service users in this group understood their own level of risk. Future research might usefully focus on the views of mentally disordered offenders towards

different stages of the supervision process. As users in Godin *et al.*'s (2007) study noted, there is a pressure on forensic service user's to 'play the game', which may often take the form of complying with professional direction or advice. It might therefore be useful to interview service users at points where conflicts emerge between service user and staff perspectives. Service users who have been recalled back to hospital will have either failed to have complied with conditions or will have been viewed by professionals or the MOJ to have been exhibiting a risk of some kind. It would therefore be interesting to interview both professionals and staff about their perspectives of recalls. Conversely, it would also be interesting to interview service users who had managed to receive an absolute discharge. In this group, issues of risk are likely to have been resolved in some way as they will have had to satisfy either the MOJ or a tribunal that the conditions for detention are no longer met. It would therefore be interesting to see how the order is viewed once service users are no longer subject to it. Ideally this research might be carried out longitudinally so that any changes in perspective during and after supervision might be noted.

In Chapter Five I measured the level of agreement between service user and professional accounts of risk. In doing so, I made use of a risk screen from one mental health trust. This decision was pragmatic, in that the majority of research participants originated or had been treated in this area (the medium secure unit covering all three Mental Health Trusts was based in the Trust using this tool). Inferential statistics, were used to understand the way in which the sample understood their level of risk. The use of this method made me aware of a number of real world practices. There were no set criteria for identifying the risks that were

listed, so raters may have drawn on their subjective understandings of the risks listed. Alternatively they might have been influenced by professional perspectives or by informal cultures within multi-disciplinary teams. The research participants were not trained in the use of the tool, so this might also provide a level of variability amongst raters. Future research might adopt a quantitative design which would seek to generalise findings across mentally disordered offenders subject to section 41. If such an approach were adopted it might seek to limit variability through using a standardised risk assessment tool. There has been a recent drive for forensic mental health staff to use measures such as HONOS-Secure. This tool provides set criteria for indicating whether certain risks are met. Using such a tool might reduce variability between raters in staff teams. Variability amongst service users might be minimised through asking them to complete the risk screen alongside a researcher who could provide guidance about rating criteria. My research used a small sample and future research might use a larger sample in order to meet quantitative standards of validity.

There has been an increased emphasis on multi-disciplinary working, which is seen as a means through which risk can be reduced. As well as being assessed by mental health professionals, mentally disordered offenders may also be managed through multi-agency protection panels which will include staff from the police and probation. Research within probation has found that whilst policy has come to be increasingly focussed on risk, professionals may resist these frameworks focussing instead on social welfarist principles (Kemshall and Wood 2007; Ugwudike 2011), although research with mental health staff working with mentally disordered offenders suggested that they may focus more heavily on public protection (Coffey

2012b). Future research might focus on the perception of mental health staff over a longer period of time and monitor changes in risk perception over this period.

An unexpected finding from my research was the lack of empathy that service users had with victims. Within criminal justice settings, admitting responsibility for offences is seen to be a pre-requisite for discharge. Remorse for offending is a key criterion for deciding whether a prisoner should be granted release. This is not the case within forensic mental health settings in which the offender is seen to have lacked responsibility for his condition and the decision as to whether to discharge is based primarily on 'insight' into mental disorder. Participants who did speak about their victims tended to stress the inconvenience caused to them by restrictive measures, rather than the potential effect of their offending on others. The focus on victim perspectives has grown steadily in the criminal justice system over the years and has come to have greater dominance within forensic mental health services recently. Victims of mentally disordered offenders placed on a section 37/41 MHA have had the right to make their views known to a MHRT since 2005 through amendments made to The Criminal Justice and Court Services Act 2000 (Home Office, 2000). Victims are not currently permitted to attend tribunals. It would therefore be interesting to review how these processes are experienced by victims. This might be done through carrying out interviews with the victims themselves and with victim liaison officers who are tasked with representing their views to the tribunals. Mental health staff are unused to such requirements and it would therefore be valuable to interview service managers and practitioners to assess their views of such legislation and their feelings toward implementing it.

Although my research has focussed on user understandings of risk in forensic settings, it has highlighted a need for future research in general mental health settings. Langan and Lindow's research (2004) demonstrated that service users in general mental health settings were rarely aware that their risk was being assessed. My research focussed on forensic service users but also found that the general level of awareness amongst service users remained low. A significant amount of time has elapsed since Langan and Lindow's research was conducted. Since their research was published there has been more Government guidance advocating that risk assessments should be shared (DOH, 2007b). However, it is unclear how far this guidance has been translated into practice and it would be timely to assess whether the process of constructing risk assessments in general mental health settings has become more collaborative or transparent.

The experiences of users in general mental health services and forensic mental health services are likely to be different. Research participants in my research were aware that staff may be particularly focussed on risk when dealing with them because of the consequences of getting decisions wrong. Harmful consequences may be seen to be either risk to members of the public or potential risk to professional reputation. Coffey (2011; 2012b) has interviewed community mental health staff involved in the supervision of conditionally discharged service users. He concludes that issues relating to public protection, risk assessment and monitoring in the community were given the greatest priority by such staff. Although the notion of 'recovery' has been increasingly referred to in mental health policy (DOH, 2011), there has been a concurrent concern to closely monitor service users whom are seen as risky or non-compliant. The introduction of community treatment orders is a

case in point. These powers were used more frequently than anticipated and recent policy has noted that they will be kept under review so that action can be taken to change the law if necessary (DOH, 2011, para. 3.40). Future research might therefore examine if there are differences between the way in staff assess service users subject to different orders. The majority of community mental health teams work with a range of service users and so research might assess how staff assess levels of risk across groups and how far this alters their approach.

### Implications for practice

This research has been carried out as part of a professional doctorate in social work. In deciding to tackle this area I was motivated by my own desire as a practitioner to have a clearer understanding of how differences in perception in regard to risk might be resolved. There is an absence of a strong social work voice within the current forensic mental health literature and I have been motivated to consider how the ethical dilemmas for practice might be understood from a social work perspective. In this next section I consider social work values alongside current law, policy and guidance in order to explore how the findings of this research might be applied.

Social workers working with service users subject to section 41 will be required to consider their practice with reference to the Health Care Professional Council (2012) standards of proficiency for social care workers. In addition to this they also have to deliver care which is in line with the requirements of the Care Programme Approach (DOH, 1999) and will also need to be mindful of MOJ Guidance (2009b). It is often difficult for social workers to navigate their way through the competing demands of professional standards, Government policy and guidance from interested agencies.

In order to examine how they might proceed it is useful to consider how these demands fit within an ethical framework. Whilst ethical frameworks do not provide solutions to problems they can be effectively utilised as a tool for considering the basis for right action.

Kantian ethics draw on the ideas of Immanuel Kant (1981). Kant's theory postulates that individuals should act in the right way driven by a sense of moral duty.

Furthermore it presumes that individuals are endowed with reason and as such are capable of making moral choices. Kant saw humans as having the ability to create normative ethics of behaviour in which unconditional sets of moral rules could be established. He believed that moral principles needed to be based on reason rather than on an individual's own circumstances. This was because what might be correct for an individual may not be generalisable to society as a whole (Hudson, 2008).

Crucially Kant saw the pursuance of moral principles as an ethical duty. The application of this form of ethics holds that human beings should always follow certain principles such as telling the truth or keeping a promise regardless of the consequences of such actions. There are a number of difficulties in applying a Kantian system of ethics to service users subject to section 41. Firstly, this group of people are judged by the legal system to have been mentally disordered. As this research has shown, most service users subject to section 41 MHA tended to stress their lack of responsibility at the time of the offence and drew on legal and medical notions to support this position. As they are seen as being without responsibility they do not fit the Kantian model of individuals endowed with reason. Secondly, in deciding whether to make an application under section 41 the court has given consideration to their potential risk to the public (Fennell, 2007). In so doing so it has



deviated from Kantian principles in that the outcome for the individual is considered in light of the wider social consequence rather than solely on individual action.

Utilitarianism ethics act in contrast to the Kantian focus on individual action. Within this approach, action is seen as morally good if it produces the best possible outcomes for society as a whole. Guttman (2006) argues that two versions of utilitarian theory exist. The first of these posits that an act is correct if it achieves the best results and that this judgement is made irrespective of existing social laws. The second version of the theory places social laws as the criteria by which right action is determined. Within this framework the good of society is considered in contrast to the happiness of the individual who makes it. Service users who are made subject to section 41 are placed firmly within the second version of this utilitarian framework as they are restricted by social laws. Seen in respect of law enforcement, utilitarian perspectives are presently interpreted as being concerned with “prevention or incapacitation and reform or rehabilitation” (Hudson, 2003, p. 19). In making a restriction order the court is considering utilitarian notions of public protection rather than placing the basis for their judgement solely on the actions of the individual. In terms of discharge a MHRT must order the release of a service user who is not judged to be suffering from a mental disorder of a nature or degree warranting detention (Fennell, para 7.87). However, these judgements still come from a utilitarian position as the consideration of risk to self or others remains, provided that the service user is judged to be suffering from a mental disorder. My research has shown that service users are aware that services adopt a utilitarian position, although they tend to see them as unjust because they may override concepts such as ‘recovery’ in mental health.

Writers on social work ethics have argued that virtue ethics may offer a better alternative to practice dilemmas than the principle-based theories outlined above.

Banks (2008) reviews these current developments. She writes (p. 1243),

challenges have come from a revival of virtue ethics (focussing on qualities of character), the development of an ethics of care (focussing on caring relationships), communitarian ethics (focussing on community, responsibility and co-operation) and pluralist, discursive and postmodern or anti-theory approaches to ethics (eschewing single, foundational all-embracing theories).

Virtue ethics can be seen to reflect the core values of social work in that they aim to take account of the social inequalities which are seen to underpin the difficulties of individuals (Banks, 2001; Clark, 2000). Webb (2006) argues that the adoption of virtue ethics should give social workers the scope to act on sociological and philosophical principles. He suggests that this framework allows a focus on social relations and is not rule bound. He goes on to argue that social workers should act as 'strong evaluators' who are able to, "exercise an ethical sensibility and judgement that's based on their ability to contrast and value the worth of things" (p.205).

Webb's vision of social workers as strong evaluators is an appealing one. However, current literature dealing with the application of virtue ethics to social work practice is still speculative in nature (Banks, 2008). In addition to this the application of virtue ethics also has certain problems when applied to service users subject to section 41. Webb's vision of virtue ethics works in antithesis to a utilitarian position. He rejects social work practice based on the notion of risk and argues that practitioners should reject rule bound systems. In taking this line Webb fails to articulate how consistency of treatment might be achieved and also fails to consider how safeguards against abusive professional practice might be imposed.

As we have previously seen, current law and policy encourages practitioners to minimise risk. Within this context social workers are faced with a number of dilemmas as to how they identify and work with risk. This chapter will now consider approaches that social workers might take and consider how these might be applied in an ethical manner. Social workers working within mental health settings will be bound to work with risk assessment tools as a result of current policy and guidance. However, as my research and other research (Manthorpe and Alaszewski, 2000; Godin *et al*, 2006) has highlighted, service users do use the concept of risk to think about their own position. My research has highlighted that service users have a tendency to focus on the risks that the mental health system may pose to them. These risks need to be considered, although social workers should not reject a utilitarian stance and will also need to consider risk to others. In using risk assessment tools social workers are demonstrating that they do not wholly reject such a stance. However, the difficulty with adopting a utilitarian position is in making a judgement as to where risk taking can be justified. The current climate of intolerance for risk taking in general tends to discourage this. As Rose argues (2002) there is a tendency for all untoward incidents to be seen as a result of failure in professional judgement. This has led to risk-averse behaviour within social work in which workers may minimise risk in order to aid defensibility (Carson, 2005). This debate has tended to focus on professional action, although my research indicates that service users are also aware of such dynamics.

The dilemma about justified risk taking may be resolved through reference to a Kantian position which sees individuals as being endowed with reason. Whilst service users subject to section 41 are likely to have been mentally disordered at the

time of their offence they may go on to regain autonomy. One of the problems within the forensic mental health system is that the autonomy of the individual is not often re-evaluated with a view to returning their legal rights. In addition to this the risks that service users may pose whilst mentally disordered or in a normal state of mind are often conflated. For example, the restriction order is seen by the MOJ to be an effective form of risk management because re-offending rates are rated as low (Fennell, 2007). However, these figures do not take account of the autonomy of the service users who do not re-offend. If social workers are to act in an ethical manner then their decision and the actions of service users needs to be evaluated in light of their level of autonomy.

The skill that social workers must adopt is the ability to work within a framework which considers risk yet does not to lose sight of the needs of the individual. Whilst compromise models between utilitarian and retributive (Kantian) perspectives exist within criminological theory, many of these models (Morris, 1982; Ten, 1987; Robinson, 1988) are concerned with the problem of managing utilitarian prevention against just desert or with balancing retribution against rehabilitation (Carlen, 1989; Matthew, 1989). These models are not easily applied to the case of mentally disordered offenders, as they are sentenced with a view to imposing treatment rather than retribution. However, rights-based approaches might provide a means by which tensions between Kantian and utilitarian perspectives might be resolved. Cavadino and Dignan (1992) refer to such perspectives to argue that individuals should have the “positive freedoms” (1992, p. 53) to make choices in their lives. Punishment is viewed as a violation of freedom and can therefore only be justified where it

impinges on the rights of another. Where punishment is inflicted it should be aimed at preventing such offending from occurring in the future.

Such perspectives might be used by social workers to judge when positive risks might be taken. In doing so they might consider public protection (from the perspective of the rights of the public not to suffer harm) whilst regularly re-evaluating the service user autonomy and ability to act in a way which would respect the rights of others. In seeking to apply an appropriate balance, social workers need to take into account service users' views. This should include their views about their reasons for offending as well as how they feel that their risk may be managed now. My research has revealed that service users hold a range of views about the reasons for their offending. As evidenced in Chapter Four, service users frequently use medical and legal notions of illness to understand their own risk. Supervisors therefore need to be able to assess how this conception of illness is understood by the individual. Although service users may refer to notions of illness to diminish their own level of responsibility, their view of illness often differs from that of conceptions held by professionals. Models of assessment in which service users are judged to possess or lack 'insight' into their mental health may fail to capture the complexity of a service user's position, so this reading of their identity needs to be regularly explored.

What this study has shown is that individuals can conceptualise risk in very different ways. However, the majority of those interviewed would acknowledge that they have posed a risk to others in the past. In considering how to build partnerships with service users, social workers need to consider the service user's view as to their

level of autonomy both at the time of offence and subsequently. Social work literature has had a tendency to focus on issues of social control with a tendency to view these as oppressive or punitive. However, a considerable proportion of service users in this research did not view restrictions as being punitive in themselves. A level of control exerted by professionals was often seen as necessary or in some cases beneficial. This was particularly the case where service users held a view of their difficulties as arising from mental illness. Those service users holding this view were essentially accepting the need for a utilitarian approach in some circumstances. Social workers might therefore usefully map out with service users the point at which they might feel preventative action may be justified. However, it was equally significant to note that most research participants were unable to recall their conditions or were unable to understand them. Service users are sent a copy of their conditions by the MOJ on discharge but are clearly not digesting them. Part of the problem may be the language in which conditions are written. Many of the conditions that I reviewed for this research were written in complex legalese that would not be understandable to those with poor literary skills. Ideally, MHRTs and the MOJ should ensure that these conditions are written simply, but in the absence of this supervisors should ensure that they are clearly explained. Conditions should also be regularly reviewed as part of the CPA process.

It would of course be simplistic to argue that service users welcome the imposition of control. As I have shown, a number believe that social supervision forms a repressive system of control. Social supervisors will continue to hold power over service users on these occasions, but this may be minimised through transparency about the risk assessment procedures that service users are subject to and the

assumptions underlying them. What this research has shown is that service users continue to largely remain in the dark as to how professionals are assessing and managing their risk. As I have already argued, social workers may need to adopt a utilitarian position at times, but should aim to work towards a rights-based approach in which service users are viewed as autonomous where they have the ability to make capacitated decisions. In order for this to occur, social workers should aim to carry out risk assessments in a collaborative manner with service users. One easy way of establishing what service users believe their level of risk to be is to ask them to identify their risks against a risk screen as I have done within this research. This may lead to service users identifying more risks that are of a concern to them. My research findings indicate that most service users felt that they had been informed rather than consulted about risk. The means through which risk is assessed should be made known to service users and they should be asked to comment and contribute to such assessments. Whilst a consensus between service users and professionals may not be reached this would act to make differences of opinion transparent. It might also open up discussion about how risk may be reduced. Service users should also be given copies of assessments. Furthermore, processes of appeal should be made known.

A number of participants have spoken of the way in which social supervision has been useful in enabling them to regain a sense of internal control. This again highlights the potential for workers to discuss such issues explicitly. In keeping with Dell and Grounds' research (1995) my research found that a significant proportion of participants did not want to be immediately free from the order. In some cases this was due to the order providing a level of disciplinary control, but more commonly it

was because the order guaranteed a certain level of support. In other words, a significant proportion valued the order not because they wanted to be restricted, but because they valued the social, relational or medical supports that it afforded. This highlights the need for an increased system of social support overall which allows individuals the ability to move away from offending identities and toward an identity as autonomous citizens.

Beck (1992) has written that we live in a society that now sees the control and management of risk as its central concern. Although risk can be seen to be a dominant issue within late-modern society interpretations of risk can differ widely and it therefore becomes important to recognise the risk perspectives of different groups of service users. Mentally disordered offenders are subject to two of modern society's most powerful professions: medicine and the law (Webb, 1999). However, this research has found that service users remain able to exercise their own autonomy. Although discourses of mental ill health were utilised by the majority of participants in this study close inspection revealed that their interpretations were often subtly different from those of professionals. Although the concept of risk was utilised by participants this also differed from that of professionals and tended to focus more on risks experienced than risks which they might impose on others. Social workers are tasked with the difficult task of maximising service user independence whilst minimising their risk. Risk management strategies have often seen risk as a thing that can be controlled through rationalistic models. However, this research points to the need for social workers to be able to consider risk assessment models whilst still considering the complexity of the views that service users may hold.



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## ***Glossary***

Absolute Discharge – In cases where a service user has been made to a section 37/41 of the Mental Health Act, the Ministry of Justice or a Mental Health Review Tribunal may grant a discharge from both the section 37 (which states that an individual can be treated on a compulsorily basis in hospital) and the section 41 (the restriction order).

Approved Mental Health Professional - This role was introduced by the Mental Health Act 2007 and replaced the role of Approved Social Workers under the Mental Health Act 1983. An AMHP facilitates mental health act assessments in the community and is tasked with ensuring that an assessment is carried out according to the legal criteria set out in the Mental Health Act 1983 as amended by the Mental Health Act 2007. This role can be carried out by a social worker, a Community Psychiatric Nurse, or a Psychologist. It cannot be carried out by a psychiatrist.

Approved Social Worker – This role was replaced by that of the Approved Mental Health Professional by the Mental Health Act 2007. The ASW role was to facilitate Mental Health Act assessments ensuring that they were carried out in accordance with the criteria set out in the Mental Health Act 1983.

Conditional Discharge – In cases where a service user has been detained under section 37/41 of the Mental Health Act 1983 (a treatment order with Ministry of Justice restrictions), the Ministry of Justice or a Mental Health Review Tribunal may grant a Conditional Discharge under section 42 of the Mental Health Act 1983. This allows for a service user to be given conditions that they must comply with in the

community. In the event that a service user does not comply with these conditions s/he may be recalled to hospital.

Community Leave – This term is used to describe leave given from the hospital to the community.

Community Psychiatric Nurse – Community Psychiatric Nurses are nurses with specialist mental health training working in the community.

Forensic Mental Health – Although the boundaries of forensic mental health services are contested, this term usually refers to specialist mental health services who work with mentally disordered offenders in hospital or the community.

Ground Leave – In cases where a service user is detained in hospital a Responsible Clinician may authorise leave within the hospital grounds. This is known as ground leave.

High Security Hospitals – These hospitals provide the highest provision of physical security for mentally disordered offenders. There are three high secure units in England (Broadmoor, Rampton and Ashworth). The Reed Report (Reed, 1992) reviewed High Secure Provision and indicated that such hospitals should provide relational security (a detailed knowledge of the service user), physical security (locks and restraints) and procedural security (policies and procedures for managing behaviour).

Home Office – The Home Office is currently the Government Department with lead responsibility for immigration, passports, drug and alcohol issues, policing immigration, counter-terrorism and equality. The functions of the Home Office were split in two in 2006 with the newly formed Ministry of Justice taking control of probation, prisons and prevention of re-offending. Whilst the Mental Health Unit fell within the Ministry of Justice may research participants had been used to being supervised through the Home office and continued to refer to it in this way.

Index Offence – This is the term that is used by forensic mental health practitioners to refer to the offence that an individual committed which led to the imposition of the section that they are detained under.

Responsible Clinician – This term was introduced by the Mental Health Act 2007 to describe the professional who has the lead role in delivering an individual service user's care. This role can be carried out by a psychiatrist, nurse, psychologist or social worker. In practice the majority of RC's are still psychiatrists.

Restriction Order – A restriction order prevents a Responsible Clinician from authorising leave to the community or discharge without the permission of the Ministry of Justice. Section 41 of the Mental Health Act restricts the discharge of service users detained under section 37 of the Mental Health Act 1983 (a hospital order imposed by a judge or magistrate). Section 49 of the Mental Health Act restricts the discharge of patients who are subject to section 47 (which allows the transfer of serving prisoners to a psychiatric hospital) or section 48 (which allows the transfer of remand prisoners to psychiatric hospital).

Responsible Medical Officer - This term used to refer to the Psychiatrist with lead responsibility for a service user whilst they were detained under the Mental Health Act 1983. The role of Responsible Clinician replaced this role under the Mental Health Act 2007.

Regional Secure Unit - These units were originally intended as a step down facility from High Secure Hospitals. Many areas now have more than one step-down facility and so the term Medium Secure Unit now tends to be used more commonly.

Social Supervision – This term refers to the compulsory aftercare provided by a social supervisor under section 41 of the Mental Health Act 1983. Ministry of Justice guidance envisages that social supervision will include monitoring of an individual's risk as well as provision of practical social support.

Social Supervisor – This is the name given to an individual providing social supervision. This role was primarily carried out by social workers in the past, but is increasingly carried out by other mental health professionals such as Community Psychiatric Nurses.

Low Secure Unit – These units provide a step-down facility from medium secure units.

Multi Agency Protection Panel Arrangements – This term refers to multi-disciplinary professional meetings for the manager of sexual and violent offenders. They are normally co-chaired by police and probation.

Mental Health Review Tribunal – The Mental Health Review Tribunal reviews the cases of those detained under the Mental Health Act 1983 in order to ascertain whether the statutory criteria are met. The panel is independent of health authorities. The meeting will be chaired by a legal member (who will be judge in the case of restricted patients), a medical and a lay member.

Ministry of Justice – The Ministry of Justice was formed in 2006. It holds responsibility for prisons, courts and probation services. Mentally disordered offenders subject to Ministry of Justice restrictions are managed through the ministry's Mental Health Unit.

Medium Secure Unit – These units provide secure psychiatric treatment for mentally disordered offenders and to lesser extent patients who are viewed as unmanageable by general mental health hospitals. These units were initially set up to provide a step down facility from High Secure Units. They were initially referred to as Regional Secure Units, although this term has become defunct as many health authorities now have more than one unit.

Regional Secure Units (RSU) – See Medium Secure Units.

## Appendices

### Appendix One – Letter to Social Supervisors and Psychiatrists

Cardiff University School of Social Sciences  
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Dear << Name>>,

As a social supervisor / supervising psychiatrist at XXXXX, I am writing to you to ask you to identify participants for involvement in a research project that I am conducting as part of a Professional Doctorate in Social Work at Cardiff University. The project is entitled:

“Service user views of risk under section 41 of the Mental Health Act 1983: how do service users conceptualise social supervision and the process of risk management within it?”

The primary research aim is to explore the views of mental health service users who have been given conditional discharge under section 41 of the Mental Health Act 1983 about risk assessment and management procedures.

#### Key Inclusion Criteria

- Service users must be subject to section 41 of the Mental Health Act 1983. Participants meeting this criteria will be eligible for inclusion within the research.

#### Exclusion Criteria

- Service users who are due to be recalled will be excluded from the research. This is because recalls are normally issued due to a relapse in mental health or through a concern that service users are not complying with the conditions that they have been given. Interviewing service users at this sensitive point may have the potential to increase their risk to themselves or others and consequently would not be ethical.
- The researcher for this project was a social worker at Fromeside Medium Secure Unit. Service users who have had the researcher act as their social worker will be excluded. This is because such participants may feel constrained in answering questions honestly due to having experienced a professional relationship with the researcher.
- Service users undergoing a high level of mental distress as identified by their care team will be excluded.

### Intervention

A semi-structured interview schedule (available on request) will guide a recorded interview. There are two parts to the interview which will be conducted together. The first part of the interview is an overview of the participant's experience of social supervision and risk assessments. The second part of the interview asks participants to name their conditions of discharge and to outline any risks that they feel that they have posed in the past using a risk screen.

### Use of data and results

Anonymised interviews will be transcribed and analysed using a grounded theory framework.

The research findings will be written up as part of a Professional Doctorate in Social Work at Cardiff University. The research will be available as a thesis at Cardiff University Library. Findings from the research will be submitted to academic journals. The research findings will be made available in lay terms for interested participants.

### Safeguards

This research has been approved by Bath NHS research ethics committee.

The research will be supervised by Dr. Jonathan Scourfield and Mr. Trevor Jones from Cardiff University School of Social Sciences, both of whom are experienced researchers.

### Further information:

The following information is available on request:

- Research proposal
- Participant information sheet
- Consent form
- Semi-structured interview schedule
- An information sheet outlining sources of support if participants feel distressed

Please contact me if you require any of the above. My contact details are:

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E-mail: [Jeremy2.Dixon@uwe.ac.uk](mailto:Jeremy2.Dixon@uwe.ac.uk)

### Next steps

I will contact you to see whether you have any service users subject to section 41 who could be interviewed as part of the research. If there are service users who would be appropriate then I will ask the social supervisor to give them an introductory letter about the research (attached) and an information sheet. Service users will be invited to contact me via their social supervisors after which I will contact them in order to discuss the research. If they still wish to take part in the research I will make arrangements to interview them.

Yours sincerely,

Jeremy Dixon  
Social Worker / Lecturer in Social Work



## Appendix Two – Letter to research participants

Cardiff University School of Social Sciences  
*Ysgol Gwyddorau Cymdeithasol Prifysgol Caerdydd*  
Director Cyfarwyddwr Professor Yr Athro Huw Beynon

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Adeilad Morgannwg  
Rhodfa Brenin Edward VII  
Caerdydd CF10 3WT  
Cymru, Y Deyrnas Gyfunol

CARDIFF  
UNIVERSITY

PRIFYSGOL  
CAERDYDD

Dear Sir / Madam

I am writing to you in order to invite you to take part in some research. I am a qualified social worker and I am carrying out the research as part of a course at Cardiff University.

The title of the research is:

### **Service user views of risk under section 41 of the Mental Health Act 1983**

I am writing to you and other people who have received a conditional discharge under section 41 of the Mental Health Act 1983. I want to find out what your experience of social supervision and risk assessments has been.

I would like to speak with you for about 60 – 90 minutes at a time and a place that is convenient for you.

Whatever you say to me will be anonymised. Your name will not be mentioned when I am writing up the research and no-one will be able to find out what you said whether it is good or bad.

Information from this research will be written up as a report that will be kept at Cardiff University Library. The results from the research will also be submitted to professional journals. A copy of the findings will also be available for people who have taken part in the research if they are interested.

I have sent an information sheet about the research with this letter. If you would like to take part in this project then please let your care co-ordinator know and I will contact you to discuss the research further.

Yours sincerely,

Jeremy Dixon  
Social Worker

## Appendix Three - Information Sheet for potential participants

### **Service User views of risk under section 41 of the Mental Health Act 1983**

#### **What is the research about?**

Service users who are detained under section 37/41 of the Mental Health Act 1983 can be given a Conditional Discharge by the Ministry of Justice or a Mental Health Review Tribunal. People who are given a Conditional Discharge are given a list of conditions that they need to keep to. They also have to see a Social Supervisor and a Supervising Psychiatrist. There is very little research that has looked into the views of service users who are subject to conditional discharge.

It is important to find out what service users think about their care. This research aims to find out the views of service users who are subject to conditional discharge. I am particularly interested in finding out about what service users like you think about the topic of risk and risk assessment. I am also interested in hearing your views about what it is like being under conditional discharge.

#### **Who is doing the research?**

My name is Jeremy Dixon. I am a social worker with ten years experience who has mainly worked in mental health services. I currently work at the University of the West of England as a lecturer in social work. I am carrying out this research as part of a course with the University of Cardiff.

#### **Why have I been approached?**

I have written to all the mental health teams within the Avon and Wiltshire Partnership in order to find out how many people are subject to conditional discharge under the Mental Health Act. I have asked care co-ordinators and psychiatrists in the teams to pass on this information to people who are subject to conditional discharge. Members of the community mental health teams will be passing this information onto most of these people. A few people will not have been contacted because it has been felt that they would find taking part in the research too distressing.

Your care co-ordinator has agreed to pass this information onto you but has not given me any details about you.

I have asked your care co-ordinator to give this information sheet to you because you are somebody who has been given a conditional discharge under the Mental Health Act. I am writing to you because I would be interested to find out your views whatever they might be.

#### **What do you want me to do?**

I would like to meet up with you and carry out a face to face interview. The interview will be in two parts which I will carry out on the same day. The first part of the interview will take approximately 45-60 minutes and the second part of the interview will take approximately 20-30 minutes. If you choose to take part in the research then I will also ask you for permission to look at any risk assessments that have been written about you. I will also ask you for permission to talk to members of your care team about these assessments if there is any information missing.

#### **Do I have to do it?**

You do not have to take part if you do not want to. If you do not wish to take part then you do not need to do anything. If you would like to be involved then please let your care co-ordinator know and I will contact you soon. If you do decide to take part then you are still free to change your mind at a later time if you want to.

#### **What will you do with the information that I give you?**

Any information that you give today will be kept confidential. It will not be shared with your care team or with anyone else. If you agree to take part in the interview then your conversation with me will be recorded. The conversation will then be written down in full by a secretary. Both the recording and the written record will be kept on a computer which is protected by a security code and which is in a

locked room. I will be the only person who has access to these files. When the research is being written up you will not be mentioned by name. When I write about the interviews in my final report I may use some of the things that you have said. However, I will not mention any information such as family names, streets or place names that would identify you. I will change the names of people and places that you mention so that they cannot be identified and I won't report any information that would identify who you are.

There are some circumstances where I would have to break this confidentiality. These situations are:

- i) If you told me that you were going to harm somebody else or seriously harm yourself.
- ii) If you told me about a child or a vulnerable person being at danger or at risk of harm.
- iii) If you informed me that you or somebody else had been involved in a serious crime.

In these situations I would have to share what you had told me with other agencies such as your mental health team, social services or the police.

I will be interviewing a number of people who are subject to conditional discharge to see what their views are. By doing this I hope to find out opinions that people have in common and whether a lot of people are noticing particular things about the care that they are receiving. When I have finished interviewing people I will write a report about what I find. I will make a short version of this report available to you if you want it. I also hope to report my findings in academic publications.

### **Will I get paid?**

Payment will be given to people taking part in the research in order to thank them for their time and to cover any expenses that they might have. A payment of £20 will be given. Payment will be given at the end of the interview.

### **What are the benefits in taking part?**

At present there is no research about what service users subject to conditional discharge think about risk assessments and management procedures. I hope that this study will fill this gap. The aim of doing this is to try and improve the way that services are provided for people in the future.

### **Are there any risks involved in taking part?**

As part of the research I will be asking you how you came to be under conditional discharge and your views about risk assessments. I will also be asking you to tell me whether you have ever been a risk to yourself or others. Some people may find that talking about these things can be upsetting or can bring up some bad memories.

### **How do I know that this is a well run project?**

This research has been looked at and approved by an NHS research ethics committee. This means that a group of people who are experienced at carrying out research have agreed that it has been properly thought out. I will also be supervised by two experienced researchers based at Cardiff University.

### **What do I do if I want to complain about the research?**

If you have any concerns or complaints about the research, then you can speak to me about it. I can be contacted on 0117 3288755. I will try my hardest to deal with any complaints or concerns that you have. If you would rather not speak to me or if you are not happy about the way I have handled your complaint then you can speak to my academic supervisor. His name is Dr. Jonathan Scourfield and he can be contacted on 029 208 74294. If you remain unhappy then you can complain through the NHS complaints system by ringing Linda Bruce-Smith – Head of Complaints on 01249 468091.

### **How do I find out more information about the research?**

If you would like to find out more about the research then please contact Jeremy Dixon on 0117 3288755.

**What happens next?**

Please let your care co-ordinator know whether you would like to take part in the research. If you do not want to take part then I will not contact you again. If you do wish to take part then I will ask your care co-ordinator to give me your contact details. I will contact you to talk to you about the research and to arrange a time and place for us to carry out the interview.

## Appendix Four – Letter to participants confirming interview time

Cardiff University School of Social Sciences  
*Ysgol Gwyddorau Cymdeithasol Prifysgol Caerdydd*  
Director Cyfarwyddwr Professor Yr Athro Huw Beynon

Cardiff University  
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Prifysgol Caerdydd  
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Cymru, Y Deyrnas Gyfunol

CARDIFF  
UNIVERSITY

PRIFYSGOL  
CAERDYDD

Dear Mr/Mrs/Ms/Miss << Name>>

Thank you for agreeing to take part in the research that I wrote to you about. I am writing to you to confirm the time that we agreed to meet. We have agreed that we will meet at <<place>>, on the <<date>> at <<time>>. If you have any questions or queries before that time feel free to get in touch with me. My contact details are:

Jeremy Dixon  
Lecturer in Social Work  
Health Community and Policy Studies  
University of the West of England  
Glenside Campus  
Blackberry Hill  
Stapleton  
Bristol  
BS16 1DD

Tel: 0117 3288755

Yours sincerely,

Jeremy Dixon - Social Work Lecturer

## Appendix Five – Consent Form

### Consent Form

**Service User views of risk under s. 41 of the Mental Health Act 1983**

**Researcher: Jeremy Dixon**

*Please tick box*

1. I confirm that I have read the information sheet for the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time.
3. I understand that the information that I give will remain secure and confidential.
4. I agree to take part in the above study.
5. I give my permission for the researcher to have access to my records and to talk to my care team in order to get information about my care.
6. I agree that a copy of this form can go into my multi-disciplinary notes.

☐☐☐☐☐☐

\_\_\_\_\_  
Name of participant                      Date                      Signature

Contact details: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Name of Researcher                      Date:                      Signature:

1 copy for participant; 1 copy for researcher; 1 copy to be kept with records

**PLEASE KEEP YOUR COPY OF THE INFORMATION SHEET AND CONSENT FORM**

## Appendix Six – Research Interview Schedule

### The views of service users subject to social supervision about risk

#### Interview Schedule

##### **Briefing and introduction**

###### - What the interview is for

I am carrying out a piece of research in order to find out the views of service users subject to section 41 of the Mental Health Act. I am interested in finding out your views and experiences of this. In order to do this I would like to ask you some questions about how you came to be subject to section 41 of the Mental Health Act and your experiences of it.

###### - What to expect today

The interview will take place in two parts. In the first part I will ask you some questions about being on social supervision and risk assessments carried out by your mental health team. This should take approximately 50-60 minutes. I will then ask you some questions about your conditions. I will also ask you to fill in a graph in order to get your views about your own risk.

###### - Pulling out

If you decide that you do not wish to continue with the interview then you are free to stop at any point. If you decide to pull out part of the way through the interview then the recording of the interview that has been taken will be erased if you tell me that you would like to happen.

###### - Anonymity and confidentiality

Any information that you give today will be kept confidential. It will not be shared with your care team or with anyone else. When the research is being written up you will not be mentioned by name. When I write about the interviews in my final report I may use some of the things that you have said. However, I will not mention any information such as family names, streets or place names that would identify you. I will change the names of people and places that you mention so that they cannot be identified and I won't report any information that would allow people to know who you are.

There are some circumstances where I would have to break this confidentiality. These situations are:

- iv) If you told me that you were going to harm somebody else or seriously harm yourself.
- v) If you told me about a child being at danger or at risk of harm.
- vi) If you informed me that you or somebody else had been involved in a serious crime.

In these situations I would have to share what you had told me with other agencies such as the police, your mental health team or social services.

###### - Payment

The interview will be held in two parts. The first part will take between 45-60 minutes and the second part will take between 20-30 minutes. The payment for taking part in the research will be £20. The money will be paid at the end of the interview.

###### - Check willingness to continue

##### **Personal Details**

Name:

Sex:

Marital status:

Ethnic origin:

Date of Birth:

Address:



## Legal History

Date of initial detention under s. 37/41 of the Mental Health Act 1983:

Date of conditional discharge:

Number of recalls from s. 37/41 conditional discharge (if any):

The amount of time spent in high secure, medium secure and low secure hospitals:

### Part 1: Qualitative Interview giving an overview of social supervision and risk

- I am interested to know how you came to be under s. 31/41 of the Mental Health Act? Tell me a bit about how you came to be placed under s. 37/41 of the Mental Health Act? Why do you think that the judge in your case felt that you needed to be placed under s. 41?
- When you were discharged from hospital you were given a list of conditions that you must keep to. Why do you think you were given these conditions?
- How has being on a s. 41 effected the way the way that your care team work with you?
- What do you think the purpose of social supervision is?
- What tasks does your social supervisor have to do under social supervision? What tasks does your supervising psychiatrist have to do under social supervision? What role do you think of the Ministry of Justice (previously the Home Office) has in your care?
- Have members of your community mental health team ever shown you a copy of your risk assessment? If yes – then who did this? What did you think of the risk assessment? Did you find it fair and accurate? Did you feel that you could influence this process in any way? (Do you feel that you have been a risk to yourself or other people in the past? Do you think that you are a risk to yourself or others now?)
- Do you think that members of your community mental health team feel that you are at risk of doing something which may be a problem or bad? If yes – what do you think they are worried about? Did you think that members of staff at the forensic hospital you were placed thought that you were going to do something that would be a problem or bad? If yes – what did you think they were worried about?

## Part 2: Focus on conditions of discharge and risk assessments

- When you were given a conditional discharge you will have been given a set of conditions that you must keep to in the community. Can you tell me what these conditions are?

.....

.....

.....

.....

.....

.....

.....

Prompt: Professionals in mental health teams complete risk assessments on all the service users that they work with. These are completed in order to highlight risks that a service user might pose to themselves or others. They also highlight if a service user is at risk of harm from others. Professionals make a record of risks that people need to be aware of now and risks that were an issue in the past. I am going to show you a list that mental health workers use in order to highlight the kinds of risks that might apply to the people that they are working with. Not all of the risks that I am going to go through will apply to you.

- I am interested to find out whether you think that you have ever been a risk to yourself or other people. Please could you tick the box if *you* think that you have met any of these risks **at any time**:

1. History of Detention/ Supervision	
Court Injunction?	
ASBO?	

2. Driving	
Fitness to drive?	

3. Self Neglect	
Neglects eating/poor nutrition, fluids? (Explanation: have you ever had periods when you have not eaten well or drunk enough because of feeling mentally unwell).	
Unsafe indoors e.g. smoking/fire/cookers?	
Unsafe outdoors?	
Has accidents resulting in physical harm?	
Physical health neglect?	
Other serious self-care problems?	

4. Suicide and Self Harm	
Life threatening attempt e.g. hanging/ laceration/ overdose? (Explanation: have you ever tried to kill yourself by doing something like trying to hang yourself, taking an overdose or by making serious cuts to yourself).	
Suicide Intent/Plan?	
Non-life threatening self harm?	
Hopelessness/ helplessness?	

<b>5. Risk from Others</b>	
Actual abuse from others e.g. sexual, physical?	
Emotional abuse?	
Vulnerable to exploitation by others?	
Neglect from others?	
Significant threats of abuse from others?	
Subject to vulnerable adult proceedings?	

<b>6. Risk to Others</b>	
Any previous violence?	
Previous serious violence?	
Previous non-violent offences?	
Threats to specific persons?	
Possession of dangerous weapons?	
Arson?	
Poor anger control?	
Violent fantasies?	
Violent command hallucinations? (Explanation: have you ever heard voices telling you to do bad things to yourself or other people).	

<b>7. Risk to Children</b>	
Threats to harm a child?	
Expressed concern about risk to children? (Explanation: have you ever been worried that you might harm a child).	
Child on Child Protection Register?	

<b>8. Additional Risk Factors</b>	
Alcohol abuse?	
Do you smoke?	
Other substance misuse?	
Serious physical illness/ disability?	
Symptoms e.g. command hallucination, paranoid delusions? (Explanation: have you ever heard voices telling you to do things? Have you ever felt that people were out to get you?)	
Limited insight?	
Unable to communicate?	
Other (specify)?	

<b>9. Risk of Loss of Contact</b>	
Extreme withdrawal?	
Difficulty in compliance with medication?	
Difficulty in relationship with staff?	
Difficulty over agreed Care Plan?	
Identified unmet needs?	

<b>10. Social Risk Factors</b>	
Recent discharge from hospital/ other transition between services or geographical area? (Explanation: Have you been discharged from hospital recently? Have you moved home recently?)	
Homelessness / recent or imminent loss of	

accommodation ?	
Significant debts / poor management of finances?	
Employment / meaningful occupation problems?	
Conflict in personal relationships?	
Domestic Violence?	
Significant losses e.g. bereavement?	
Lack of social support?	
Poor housing?	
Difficulties with neighbours?	
Other (specify)?	

- The researcher will give the participant time to discuss their feelings after filling in the above chart. He will check whether they feel alright and whether it has brought up any unpleasant memories. The researcher will check whether the participant is suffering from any distress as a result of the interview. The researcher will discuss these feelings with the participant and appropriate ways of dealing with any distress experienced. This discussion is intended to appropriately support the participant and no data will be recorded as a result of this discussion.

## **Debriefing**

We have come to the end of the interview. Thankyou very much for taking part.

Are you ok? Some of the things that we have talked about today may have brought up some bad memories. I have got a list of people who can provide you with support if you feel upset a bit later or feel that you need to talk about things. [Give support information sheet].

Remember that everything that you have told me today will remain confidential. Nobody else will know what you have told me.

- Check whether the individual wants to receive a copy of the research findings
- Ask if there are any questions that the participant wants to ask the researcher. Are there any comments about the interview that the participant wants to make?
- Give the money
- Thank again.

## Appendix Seven – Example of list of support agencies given to participants following the research interview

### Service User support for [name of city deleted]

#### Community Mental Health Support

If you want to talk to mental health professionals about issues that are distressing you, then your care co-ordinator will often be able to help. They will be able to talk to you themselves but will also be able to advise you of other services in your area.

#### Support through other groups

There are a number of groups and charities that aim to provide emotional support.

Purple Pages can give you information about support groups and mental health support in your area. They can be contacted between 09.30 a.m. and 5.00 p.m. Monday to Thursday and 9.30 a.m. to 4.30 p.m. on Friday. Their telephone number is 0808 808 5252.

You could also contact one of these groups:

#### Rethink Advice Line

Rethink is a national mental health charity. They run an advice and information line for users of mental health services and their carers. They are open between 10 a.m. – 3 p.m. on Monday, Wednesday and Friday and between 10 a.m. and 1 p.m. on Monday and Thursday. You can contact them on 020 8974 6814. You can also contact them by e-mail on [advice@rethink.org](mailto:advice@rethink.org)

#### [Name of city] Samaritans

The Samaritans offer confidential and emotional support to people who have personal crises. Samaritan volunteers are trained to listen without judgement whatever the concerns of the caller. You can ring [city deleted] Samaritans on [number deleted] twenty four hours a day, every day. The office is also open to callers in person from 9:00am to 10:00pm each day.

#### Support out of office hours

#### [Name of City] Crisis Team

This is a service that helps people with a mental health problem in times of crisis in the [geographical area] area. The team provides support to service users who are already seen by mental health services. They can be contacted 24 hours a day on 01452 891227.

#### Mindline

Mindline is an out of hours telephone helpline. They offer emotional support for people experiencing distress. They can also provide information about other mental health services. You can contact them by telephone on 0808 808 0330 on Wednesdays to Sundays between 8 p.m. and midnight.

#### Samaritans

Samaritans provides non-judgemental emotional support 24 hours a day. You can contact them by telephone on 08457 90 90 90

#### Saneline

Saneline is a national out-of-hours telephone helpline offering emotional support and information for people affected by mental health problems. You can contact them by telephone on 0845 767 8000 between 6.00 p.m. and 11.00 p.m.

## Appendix 8 – Coding Frame

I began coding on the interview transcripts themselves identifying themes with coloured markers. I entered these codes into Nvivo in order to aid organisation. I then read through the transcripts a further time carrying out a further level of analysis. These sub-codes were documented in Microsoft Word documents. The following coding tree amalgamates the codes which were entered into Nvivo with those which were identified subsequently within Word documents.

Nodes		
Participants' views of own risk	a. Context of risk	<ul style="list-style-type: none"> <li>i. Mental ill health on the part of the participant</li> <li>ii. Emotional distress experienced by participant</li> <li>iii. Drug and alcohol misuse by participant</li> <li>iv. The perception of persecution by others</li> </ul>
	b. View of risk in the past	<ul style="list-style-type: none"> <li>i. Offence seen as a consequence of symptoms of illness</li> <li>ii. Offence seen as a consequence of problematic drug or alcohol misuse</li> <li>iii. Offence viewed as a justifiable action in response to provocation by others.</li> </ul>
	c. View of risk now	<ul style="list-style-type: none"> <li>i. Risk viewed as historical</li> <li>ii. Risk controlled by medication</li> <li>iii. Risk controlled by new ways of thinking</li> <li>iv. Risk minimised by the deterrent factor of the order.</li> </ul>
Professional response to risk	a. Perception of staff role in relation to risk	<ul style="list-style-type: none"> <li>i. Risk reduction through medical treatment</li> <li>ii. Risk reduction through supervision of service user behaviours</li> <li>iii. Staff response to risk is unclear to service user</li> </ul>
	b. Staff attitude to risk	<ul style="list-style-type: none"> <li>i. Staff aware of risk to own reputation</li> <li>ii. Staff prioritising support over monitoring</li> </ul>
	c. Staff response to risk	<ul style="list-style-type: none"> <li>i. Prioritisation of safety</li> <li>ii. Professional disagreements</li> </ul>
Risk assessments	a. (non) awareness of risk assessments	<ul style="list-style-type: none"> <li>i. Incidences where risk assessments were shared</li> <li>ii. Incidences where service users confused risk assessments with other measures</li> <li>iii. Incidences where staff informed service users of risk categories without providing further information.</li> </ul>
	b. Construction of risk assessments	<ul style="list-style-type: none"> <li>i. 'High' and 'low' categories</li> </ul>
	j. Negotiations with team	<ul style="list-style-type: none"> <li>i. Lack of power</li> <li>ii. Persuading staff of risk status</li> </ul>
	k. Purpose	<ul style="list-style-type: none"> <li>i. As a staff monitoring tool</li> <li>ii. As a means of identifying and reducing stress</li> </ul>

## Appendix Nine - Graph illustrating participants' understanding of their conditions

Pseudonym of Participant	Conditions Correctly identified	Conditions partly identified	Conditions omitted	Misunderstandings of conditions
Ben	<ol style="list-style-type: none"> <li>1. I must submit to drug screening.</li> <li>2. I must see doctor.</li> <li>3. I must see my social worker.</li> </ol>		<ol style="list-style-type: none"> <li>1. I must see members of the clinical team including the CPN.</li> <li>2. I must reside as and where directed by the RC.</li> </ol>	<ol style="list-style-type: none"> <li>1. I need to take medication.</li> </ol>
Christopher	<ol style="list-style-type: none"> <li>1. To take drug tests on occasion.</li> </ol>	<ol style="list-style-type: none"> <li>1. To stay in contact with my team (the conditions stipulate that he needs to attend appointments with RC and Social Supervisor rather than just staying in contact with them).</li> <li>2. I must reside at a place of my team's choosing (the condition states that this authority is given by the RC).</li> <li>3. I must not go into [names town] (this is laid out by a map, rather than just being given as a place).</li> </ol>	<ol style="list-style-type: none"> <li>1. To accept all prescribed meds</li> <li>2. To comply with all treatments.</li> <li>3. The patient is not to attempt to make any contact with the victim [name] or any member of his immediate family.</li> </ol>	
Daniel	<ol style="list-style-type: none"> <li>1. I don't partake of illicit drugs.</li> </ol>	<ol style="list-style-type: none"> <li>1. I reside at this address (the conditions stipulate that the address needs to be approved by RC and social supervisor and be in a named city).</li> <li>2. I in no way attempt to contact [victim 1] (the conditions also state that he should not approach the victim's wife).</li> <li>3. I am excluded from [town 1], in fact</li> </ol>	<ol style="list-style-type: none"> <li>1. That an RC and Social Supervisor in the Community be identified.</li> <li>2. That he submits to supervision by his RMO and Social Supervisor.</li> </ol>	<ol style="list-style-type: none"> <li>1. I subject myself to MAPPA control.</li> </ol>



		<p>now I'm excluded from [town 2] and [town 3] as well, so there's exclusion in effect (the actual conditions state that if an elderly parent became unwell he would need to contact MOJ to discuss).</p> <p>4. I take medication (the conditions stipulate the need to take anti-psychotics, rather than just medication).</p>		
Eric	1. To see my doctor and social worker at specified times.	<p>1. Not to take illegal drugs (conditions also state that he should provide samples of urine for analysis when required or at random intervals).</p> <p>2. Not to drink (conditions state that he should not drink to excess, rather than to not drink altogether).</p>	<p>1. To reside at an address acceptable to the RC.</p> <p>2. To take all prescribed meds.</p> <p>3. To be subject to social supervision.</p>	
Francis		<p>1. Not to take illegal drugs (conditions state that he must also submit to random drug tests)</p> <p>2. To see RC (but omits direction to comply with meds and treatment)</p> <p>3. To carry on seeing Social supervisor and comply with the care team (although he thinks that he needs to see them weekly, which is not the case).</p>	1. That you live at [names residential home] or any suitable housing approved by RC.	1. To see housing worker.

Grace	<p>1. To attend upon her community RC Dr. W or his successors when requested to do so and follow his medical directions.</p> <p>2. To attend upon Mr. S social worker or his successors when requested to do so and follow his directions.</p> <p>3. To reside at an address in [names county] easily accessible to the patient's sister's home or some other address as her RC shall approve.</p> <p>4. Not to consume alcohol in excess of 4 units per week on any occasion and not in excess of 14 units in any calendar week.</p>			
Henry	1. Not to take illicit drugs.	1. To see my social worker (conditions also state he should comply with medical and supervision).	<p>1. To reside at 24 hour staffed hostel as approved by RC.</p> <p>2. To comply with medication.</p> <p>3. To comply with the treatment plan.</p> <p>4. To drink alcohol only as agreed by the Clinical Team.</p> <p>5. To comply with random and / or regular testing for illicit substances and / or alcohol.</p>	1. To see the support worker.

Ian	1. To give random urine / breath tests.	<p>1. To see Social Supervisor and CPN (condition actually states that he should also see other team members).</p> <p>2. To do something positive with my time.</p> <p>3. To see Doctor (condition also states that he should comply with his / her directions as to medication and treatment).</p>	1.To reside at a 24 hour staffed placement approved by the RC and Social Supervisor	
Michael		1. To take injection (conditions state he should take medication as required).	<p>1. To reside at [named residential unit].</p> <p>2. To submit to planned and random drug screens.</p> <p>3. To abide by the rules of [residential home] and to abide by the instructions of staff and the RC.</p> <p>4. To attend appointments with psychiatrist.</p> <p>5. To attend appointments with social supervisor.</p>	<p>1. To take no illegal drugs.</p> <p>2. To only go to [named county] if escorted.</p>

Neil	<p>1. To refrain from taking illegal drugs and submit to random drug screens.</p> <p>2. Live in appropriate place as agreed by Social Supervisor and Responsible Clinician.</p> <p>3. Not to contact victim's family.</p>	<p>1. Overnight leave only to be taken if permission given by social supervisor (conditions specify that overnight leave can only be taken at one address named in the service user's conditions).</p> <p>2. Not to go into 25 mile radius of area where the index offence took place (conditions state that an exception may be made to this if authorised by social supervisor. If the social supervisor gives permission then he can visit his brother provided he goes by bus or train. He is not allowed to drive through the exclusion zone in a car).</p>	<p>1. The patient shall attend upon his RC as required and comply with his directions as to medication and treatment.</p> <p>2. The patient shall attend upon his social supervisor and other members of the care team as required and comply with their directions as to the programme of activities which shall be devised for him.</p>	
Oliver	<p>1. Not allowed to visit bookies.</p> <p>2. Not to sleep outside of residential home without permission (conditions don't state who should give permission).</p>	<p>1. Stay at current (residential) accommodation (also states he is required to meet with staff there on a weekly basis).</p> <p>2. Not to go anywhere else overnight without permission (subject to a curfew from 6 p.m. to 6 a.m. to be reviewed at a forthcoming CPA).</p>	<p>1. The patient shall attend CPA meetings every 3 months.</p> <p>2. The appointeeship as to the service user's finances shall be kept in place.</p> <p>3. The patient shall participate in daytime activities organised at [name of accommodation].</p> <p>4. The patient is forbidden from taking or using illegal drugs whilst at [name of accommodation] or elsewhere.</p> <p>5. The patient shall make himself available to both his social worker and psychiatrist.</p>	<p>1. I can only stay with Mum and not elsewhere and if over 7 days permission is needed (conditions state that he is not allowed to stay with his mother at all for the time being and may only visit with the permission of the social supervisor and supervising psychiatrist).</p>

Phillip		<p>1. To abide at [name of supported accommodation] (conditions also stipulate that the service user should reside at this address or any other approved by his Responsible Clinician and Social Supervisor).</p> <p>2. To make sure that I go to appointments with the care team (conditions also stipulate that he should accept treatment and supervision from his psychiatrist and from social supervisor and from forensic team).</p>		<p>1. To have overnight leaves as designated by social supervisor or RC.</p>
Quentin			<p>1. To reside at [name of supported accommodation] or such other accommodation as shall be approved by the Responsible Clinician and Social Supervisor.</p> <p>2. To abide the rules of such accommodation.</p> <p>3. To accept medical supervision by the Responsible Clinician and to comply with treatment plans including the taking of medication and attendance at out-patient and other appointments as to be prescribed or directed.</p> <p>4. To accept supervision by the social supervisor and receive outreach services from the community mental health team and to abide by their requirements including participation in rehab</p>	<p>1. I am allowed to be in [named County] during the day time but must return to his home address by midnight.</p> <p>2. If a police officer speaks to me, I have got to speak back to them in the same way.</p> <p>3. If anyone speaks to me, I have to speak to in a civil tongue.</p>

			programmes.	
Richard	1. To take medicine prescribed by the doctor.	1. I need to live where MOJ tell me to live - initially a high support hostel and now a low support house (the conditions state that he must live at a place as approved by the social supervisor, except when an informal patient in hospital).  2. To stay in touch with my doctor (conditions stipulate that he needs to allow access to his RC, Social Supervisor and Care Co-ordinator).	1. To abide by the rules of [name of residential home] or any other premises in which he shall reside.  2. To give regular drug screens.	1. Not to take illegal drugs.  2. MOJ need to agree any overnight leaves.  3. To attend CPAs.
Sally	1. I'm not allowed to consume alcohol.  2. I must see my social supervisor and do what he says.	1. I must live at an address specified unless given permission to do otherwise (conditions state that permission must be given by RC).  2. I must comply with treatment (conditions specify that she should comply with medical supervision and treatment by RC or his / her deputy).		
Tony	1. I must live at an address unless I get permission otherwise.  2. I need to see a social supervisor and do what he says.	1. I must comply with treatment (also needs to see supervising psychiatrist).	1. To be subject to random drug tests  2. That he should not go to [named town].	1. I'm not allowed to consume alcohol

Vic		<p>1. To live at a particular place (conditions state that accommodation should be 24 hour staff supervised and that he should attend meetings with his social supervisor.</p> <p>2. To take medication (although he identified this, he was not sure if this was formally stipulated in his conditions).</p>		
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## Appendix 10 – Literature Search Strategy

Relevant papers were identified through searching social sciences, medical, psychological and publisher databases. Sociological databases used were ASSIA, Ethos, JSTOR, Social Services Abstracts, Social Sciences Citation index and Social Policy and Practice. Medical and psychological databases used were BioMed Central, MedLine, Pubmed, Psycinfo and the Science Citation Index. Publisher databases searched were Sage Journals Online, Taylor & Francis and Wiley Online Library. Keywords were used to search for relevant material in both titles and abstracts. Key words used were “mentally disordered offenders” and “risk”; “social work” and “risk”; “forensic mental health” and “risk”; “forensic psychiatry” and “risk”; “social supervision”; “forensic psychiatry” and “supervision”. Reference lists were used as a means of identifying further articles. In addition to this I contacted Dr. Michael Coffey from Swansea University and Dr. Paul Godin from City University in London to ask whether they were aware of any recent literature. These authors were identified because they had both recently written on service user perspectives of forensic mental health care. Where relevant articles were identified author searches were conducted through Google Scholar to identify whether the same authors had written other relevant articles.