Playing the game: service users' management of risk status in a UK medium secure forensic mental health service

Authors:

Lisa. M. Reynolds[a]*, Julia.C. Jones[b], Jacqueline. P. Davies[b] and

Della Freeth, Institute of Health Sciences Education, Queen Mary, University of London

Bob Heyman[c], Centre for Health and Social Care Research, University of Huddersfield.

[a]Division of Health Services Research and Management, School of Health Sciences, City University London, UK, [b]Division of Adult Years, School of Health Sciences, City University London, UK and [c]Centre for Health and Social Care Research, University of Huddersfield

Short title: forensic mental health service users' management of risk status

E Email for correspondence Lisa Reynolds,.email: l.reynolds@city.ac.uk.

Abstract

In this article we examine how forensic mental health service users actively attempt to manage their risk status through *playing the game* of containing frustration and demonstrating compliance. The article draws on an observational study (2006 to 2009) which explored the practices of risk assessment and management within one inner city forensic mental health medium secure service in the UK. We used a grounded theory approach to explore service users and providers experiences of risk assessment and management. We interviewed forensic mental health service users and providers. We also collected data using participant and non-participant observation. Since access to forensic mental health services is tightly controlled, there are participant observation studies undertaken in these settings.

We found that service users attempted to understand the system of assessment and sought to affect and reduce their risk status by engaging in overt, compliant behaviours. We argue that in doing so service users are active agents in the process of risk management. However, we indicate that there are adverse effects of this approach to risk management as the risk assessment process is subverted by the restriction of the flow of information, and service users are left with frustrations that they must contain and manage.

Introduction

In this article we argue that forensic mental health service users actively manage their own risk status by regulating their communication of risk indicators. We use data from a study of a UK medium secure unit to explore how mental health service users suppressed verbal and behavioural communication of risk indicators with the aim of reducing their risk status and so enabling them to achieve greater levels of autonomy and freedom. We give examples of service providers' responses to service users' attempts to actively manage their risk status, including the active encouragement of the silencing of indicators. Thus beyond the existence of an inadvertent *inductive prevention paradox* in which risk management interventions block the flow evidence needed for risk assessment (Heyman et al 2013), we found evidence of an active damping down of the communication of risk indicators by service users. Such damping down makes it unclear whether reduced risk indicators are evidence of a sustained change in the service users' risk status or, in a manner reminiscent of Goffman's work on asylums (1961), this is a deliberate subversion of the process of risk assessment upon which the forensic heath care system is based.

Forensic mental health care and risk

Forensic mental health services provide care for people who have been in contact with the criminal justice system and who also have mental health problems. Users of medium secure forensic mental health services have usually been convicted of an offence and have been diverted from the criminal justice system into health care to receive treatment for their mental health problems. Thus forensic mental health services operate on the edges of both mental

health and criminal justice systems; tasked with promoting service user autonomy within a recovery framework in which service users work in partnership with health care professionals to regain control over their lives. Services should support service users to manage their own risk and recover a meaningful social identity (Bonney and Stickley 2008; Anthony 1993), whilst at the same time ensuring public safety.

Secure forensic mental health services are stratified into high, medium and low secure services (Rutherford and Duggan 2007). Service users are categorised according to the risk that they present and assigned to the service with the required level of security. Each service is further stratified into levels of security and service user risk; ranging from highly staffed and physically secure intensive care units to rehabilitation and pre-discharge areas that are subject to less physical and procedural security measures. Service providers use risk assessment to determine where in the forensic system a user is to be placed, and the level of restriction that they may be subject to. Risk assessment is therefore central to the functioning of forensic mental health services, providing a way to balance service user autonomy with safety. In this way forensic mental health services operate as risk escalators (Heyman, et al 1998; Heyman et al 2004); that is they function as systems that operate to manage defined risks. Compromises are made between security and autonomy as the service user moves through the system. Risk escalators have defined steps in the treatment regime in terms of risk and can move service users upwards to increase safety or downwards to increase autonomy (Heyman et al 2004). The final step is for service users to be fully discharged from secure care. At this point service users must be trusted to take control and responsibility for the self-management of risk, often with only intermittent supervision from community services.

In the context of forensic mental health care, service users need to be able to cope with restrictions on their autonomy in order to progress to be given greater freedoms. Reminiscent

of Goffman's work on institutions, assessed risk may become overlaid with compliance with institutional regimes in which *good* patients who are inconspicuous and perceived to be harmless are rewarded with greater freedoms (Goffman 1961). Thus it could be argued that service users are actively engaged in the process of risk management even if through a *cynical* performance of docility and compliance. Strategic action by service users to manage their risk assessment (Godin et al 2007) is back-grounded in assessments using formal assessment tools.

There is a plethora of risk assessment tools available that service providers can use to assess the specific risks of forensic mental health service users, such as the HCR-20 violence risk appraisal scheme (Webster et al 1997) and Violence Risk Appraisal Guide (VRAG) (Quinsey et al 2006). However, these risk assessment tools focus on static risk indicators which are more reliable amenable to modification than dynamic risk indicators. Of the twenty items in the HCR-20, ten are Historic, and therefore static and unchangeable; five Risk and five Clinical. The VRAG is also weighted towards static risk indicators, and starts with a question about whether the individual lived with his biological parents until the age of 16; another example of a static indicator. Thus the pursuit of accurate risk prediction appears counter to the provision of recovery based care. Research continues to attempt to assess the dynamic risk factors using new technologies such as online simulation (Arborelius et al 2013); however in practice, risk assessment remains a day-to-day challenge for clinicians.

Risk assessment continues to be a largely subjective process. Professional judgement under pins the assessment of risk, whereby the outcomes of actuarial assessments are further interpreted and modified by clinicians (Ward et al 2007). Therefore apparent systematic and objective assessments of service users' risk may in fact be based on professional judgement.

Clinicians' judgement may be affected by factors beyond the users' presentation (Kemshall and Wilkinson 2011). These factors include accountability to employers and professional bodies, experience and knowledge base. Furthermore the limitations of actuarial risk assessment tools may not be fully understood or taken into account by assessors.

Regardless of the validity of the assessment made, risk management decisions have to be made by clinicians and risk status calibrated in order that users may be categorised and accordingly placed within a specific security level in the forensic mental health system. Screening risk assessments for users of health services categorise people according to their level of risk. Individuals are then afforded a personal risk status consistent with the category in which they have been placed. Users are subject to personal and social pressure to move out of the high risk category by changing their behaviour (Heyman et al 2010). In forensic mental health services risks selected for screening are largely those that are associated with offending, such as physical and sexual violence. Risks are selected by clinicians for intervention. This selection creates crude risk categories which are often evident in risk documentation, and demonstrate a binary contrast between security focussed risks and iatrogenic risks relating to service user autonomy. Security focussed risks dominate the literature and practice, they include: risk to the public and others; to the organisation; to health care workers. Iatrogenic risks, the harm to forensic mental health service users of dependence and institutionalisation are largely a secondary consideration. Thus the relationship between safety and service user autonomy may become unbalanced as risk discourses pervade and shape care provision which was intended to be for social integration and rehabilitation (Coffey 2011; Rose 1998). The heightened risk status of forensic mental health service users is reflected in the higher level of security within forensic services compared to generic mental health services. Unit doors are reinforced, units are surrounded by fences, and service users' access to many everyday items such as pens may be restricted

and monitored. It is likely that the risk status of users of forensic mental health services will always be elevated when compared to that of generic mental health service users. Users may be unable to distance themselves from their histories of offending. Thus service users may become 'locked into deviant identities' due to their offending histories and struggle to create a new identity which would enable them to integrate into everyday life (Coffey 2011).

Having a high risk status is an inherent part of being a forensic mental health service user; the risk status of forensic mental health service users is based on their offending behaviour, and so is inextricably linked to and classified as *forensic*. The challenge for forensic mental health services is to prepare service users to be safely discharged into the community. Thus the organisation must judge when, despite their forensic label, a user's risk status has been reduced sufficiently to be considered acceptable within a community setting. However, it is not always possible to know with any confidence whether an individual will reoffend seriously or not (Heyman et al 2013). The best that can be done is probabilistic prediction of recidivism, the assessment of which is problematic.

In this article we will explore ways in which users of forensic mental health services respond to risk assessments in an attempt to to manage their risk status and so promote their progress towards discharge. We see service users as active agents of risk management rather than the passive recipients of care.

Methodology

The findings presented are from a single site case study of an inner city medium secure forensic mental health service in the UK. We used a modified grounded theory approach which enabled us to explore service users' and providers' experiences of risk assessment and

management in forensic mental health care (Strauss and Corbin 1998). We collected data from 2006 until 2009. In the study we explored how service users and providers experienced the provision of mental health care and more specifically, how tensions between safety and autonomy were managed.

We obtained ethical approval for the study from the local NHS research ethics committee (LREC) 26 June 2006 reference 06/Q0803/64 and permission for access from the managers of the medium secure unit. However, this was subject to the agreement of service users and clinical staff. Due to the high profile of the service and the high risk status of the service users gaining access and seeking consent to undertake observation was not straight forward. While we were undertaking the study the research site was the subject of a public inquiry which attracted a significant amount of media attention, and resulted in restrictions being made to previous access agreements.

We provided as all participants with information sheets regarding the study were given out to and these were also displayed on notice boards. However, some service users were unable to read the information and needed time to discuss the study with the researcher. During a period of observation, a service user's mood or mental state could change; or a person who did not have the capacity to consent could be admitted into the service. If a service user was not able to provide consent to be observed then we asked for their retrospective permission or we removed any observation of them from the field notes. Following the work of Quirk and colleagues, who undertook an observational study of a mental health unit (Quirk et al 2004), we also suspended data collection if a service user or provider indicated by their body language that they were not comfortable being observed.

As the study progressed concerns about maintaining the anonymity of participants arose. Female service user participants could be easily identified from the data, service user

participants if formally interviewed could be identified as permission was needed from their clinical team for interviews; and for safety and security interviews had to take place in the clinical area with the knowledge of the nursing team. To address these concerns all participants were given male pseudonyms and interviews with users took place informally as part of the observation rather than as formal interviews.

We collected data through participant and non-participant observation as well as in-depth interviews. We interviewed with service users as part of the process of observation as it was not possible to maintain anonymity when interviewing service users formally as they needed to be risk assessed and potentially escorted by members of their clinical teams. We draw on these observation data is presented in this article.

We undertook observation for approximately four hundred hours over a period of eighteen months. We spent time with the research participants and engaged with their day-to-day activities, and had many spontaneous informal conversations, which formed part of participant observation (Hammersley and Atkinson 1995; Cheek 2000). We included records of informal interviews and conversations in the written field notes. We used the grounded theory approach analysing the data as it was being collected using techniques of theoretical sampling, and constant comparison.

Findings

We present our findings will be presented in two sections. We start by examining service user perspectives on forensic mental health risk categorisation and then explore their attempts to manage their risk status through regulating their communication. For the purpose of confidentiality service user participants have been given pseudonyms.

Service user perspectives on forensic mental health risk categorisation

In the forensic unit we found that that service users did not necessarily understand or accept the heightened risk categorisation and increased security measures that it mandated. Charles,a service user voiced his objection to the blanket restrictions imposed on forensic mental health service users which are different from those who are in the non-forensic mental acute wards:

> *In the acute wards they have metal knives and forks and they are unwell* [points to his head]. *They self-harm with them. People in here are compos mentis and we have plastic!* (Charles, service user)

Charles did not take into account his forensic label and past history of offending when comparing his risk status with that of other mental health service users. Risk status was correlated with a person's mental state; the more mentally unwell a person was the greater risk they presented to themselves and to others. Thus risk was situated and confounded with the mental health focus of the service. The service user selected and focussed on mental health status as a risk; however, the risks that were selected by the service were those concerning offending behaviour. Thus the service user selected risks which were modifiable, and which allowed him to shed his high risk status. In focusing on the risks associated with mental illness the service user might then ignore the impact of their offending history. However, the service focus was on offending behaviour, a static risk indicator which afforded the service user with a long term label.

Another service user Zach, attempted to make sense of the reasoning behind the forensic service's reliance on histories of offending behaviour for the assessment of risk.

> *I have been here for 5 years it's because of my index offence; you are punished according to what you did. I realised straight away what I did was wrong, and I won't take drugs when I go out. Others who have done less but don't realise are let out*

sooner. Just because someone has only committed ABH [Actual Bodily Harm] *doesn't mean the next time they might do it badly enough to really hurt or kill someone. How do you tell the difference between the two?* (Zach, service user)

Zach highlighted the problems with basing risk status on past offending behaviour, in particular the difficulty of accurately predicting a person's behaviour post discharge. In his discussion Zach questioned the way in which past behaviour was crudely used to predict future behaviour, and set risk status. It was unclear how the use of past behaviour to predict future behaviour could encompass escalation or reduction in the nature or frequency of offences committed. Legal, health and risk classifications, terminologies and frameworks have become confounded. Here mental health and justice systems merge to become a *treatment and control system* (Dallaire et al 2000). Actual Bodily Harm (ABH) is a legal classification of a violent offence which attracts a particular legal penalty, and should not attract the same response within a mental health framework which is focussed on therapy and recovery rather than punishment. However, Zach was arguing that legal frameworks were being applied within a mental health setting.

Zach highlighted contradictions within the system and challenged the confounding of the legal and medical approaches within the forensic services. He challenged the logic behind the use legal classifications such as Actual Bodily Harm to inform risk prediction. If detention is a punishment linked to the offence committed it does not make sense to release people early if they have committed serious offences. However, if early release is based on risk predication rather than punishment for the offence, how can that be based on the offending behaviour? Legal distinctions are made between the severity of violent acts and punishment takes into account past behaviour, not future risk. Furthermore the offence committed may not be due to conscious decisions made by the perpetrator but due to the circumstances;

which could reduce or exacerbate the violence used. It was difficult for users to accept that a complex act be used so crudely to predict the future and assign risk status?

Zach highlighted a difficulty with relying on static risk indicators such as past offending behaviour rather than dynamic risk indicators such as service users' current insight and attitude towards offending. The focus on past behaviour potentially conflicted with therapy, as therapy and attitudinal change would not, in face of serious past offending reduce a service users' risk status sufficiently to enable them to progress towards discharge. Therefore their motivation to engage with therapy, confront difficult issues and accept responsibility could be diminished. Lack of engagement with therapy then created a negative self-reinforcing spiral whereby risk status was increased due to lack of compliance with therapy. Non-compliance then becomes erroneously equated with risk.

Service users' attempts to manage their risk status through regulating their communication

Given the unknowns and subjectivities in apparent technical approaches to risk assessment, service users attempted to ascertain their risk status from the cues in their environment. Service users needed to understand organisational and professional cultures so that they could adjust their behaviour to and achieve a reduced risk status which would enable them to progress towards discharge. Thus service users adapted their behaviour to meet the perceived demand characteristics of the institution, rather than addressing their problems concerning their mental health or offending behaviour.

The strategies employed by service users to manage their risk status centred around the regulation of communication; the non-reporting of problems and demonstration of compliance. These two areas are discussed below, together with the problems encountered by clinicians in assessing risk status when a service user is regulating their communication.

During an interview the researcher asked Graham, a service user about his behaviour. He explained that he sat quietly and did not complain about his care, despite his frustrations, as he did not wish to slow his progress towards discharge.

> *There are vulnerable people in here and they* [staff] *are taking advantage of that. I have said too much already, people on the ward may find out … anyway I am not here forever, I will just need to play the game and wait … you need to train yourself, get used to just sitting.* (Graham, service user)

Graham silenced his complaint, as to complain would be to adversely affect his progress towards discharge. He perceived that expressing his dissatisfaction with care might be included in structured risk assessment tools as a risk indicator, or interpreted in terms of lack of insight, noncompliance or not being responsive to treatment; all of which are items in risk assessment check lists such as the HCR20, behavioural status index, which have become used as standard within forensic mental health services (Khiroya et al 2009). Therefore expressing frustrations with care could result in an elevated risk status and reduction in freedoms. However in not making his complaint the Graham had to contain his frustrations and cope with an unchanged situation.

Servie users could demonstrate their compliance through being available and observable. A service user could make himself both visible and yet invisible by being quiet and not causing any problems. This was not easy, it required self-discipline and patience.

Justin took a similar approach, however he found 'playing the game' frustrating.

> *I'm sitting here interacting. If I sit in my room I am either isolating myself or*

antisocial! (Justin, service user)

As with Rosenhan's seminal study (Rosenhan 1973) everyday behaviours might incorporated into frameworks of deviance as part of the process of assessment. Justin was   decribeing a strategy of actively managing his behaviour to in an attempt to improve the outcome of his risk assessment. He felt he had no choice but to play the game and he was angry that he had to do so. However showing that he was angry might also be interpreted as a risk indicator; therefore he had to learn to contain and mask his anger for his acts of compliance to be effective. Justin, like other service users, was unable to address the cause of his anger and had to live with these uncomfortable feelings; but the effect of his self-control was to limit the flow of information about his mental health and therefore the effective of risk assessment.

Sam described how he managed his frustrations with the need to perform compliance.

> *When I get out I will write a list, this and that, this and that* [demonstrates a list down his arm]. *But I keep quiet, I am compliant … if I say anything then I am arguing, then I am argumentative so I keep my mouth shut*. (Sam, service user)

Sam has chosen not to report his dissatisfaction with care as he felt that his complaint would be pathologised. As with Graham, Sam demonstrated his compliance by keeping quiet. Sam was responding to two perceived demand characteristics within the environment; to demonstrate compliance and withhold complaint. To complain or be non-compliant would be to challenge the social order and so potentially present him-self as a greater risk to the organisation. Sam contained his frustrations by writing a list, he had not accepted these infringements, he would assert himself when he was outside and so maintained his identity whilst demonstrating that he was a good, compliant patient.

Mark described how the patients talk to each other about their lives and so maintained the identities that they had prior to admission.

> *... the patients help each other, don't trust the doctors and nurses. They are authority figures. The patients meet in the evenings and talk about what happens day-to-day, keep in touch with reality, with our reality and the outside world* (Mark, service user)

Mark was describing the existence of an institutional under-life, a resistance culture in which the institutional mission of transforming mentally disordered offenders into patients who might be safely discharged back into the community was subverted. In terms of Goffman's *Asylums* this represents colonisation; the service users accepted the need to display compliance, but resisted genuine transformation to become ideal patients. They had created a space outside of the managed time on the ward, where they could safely retreat from the hospital systems which threatened to destroy their old self, and through talking connect with their previous roles and the self that existed outside of the hospital.

Playing the game was largely an unspoken activity. However John did name the game and vented his frustrations during a ward round meeting when he felt that his efforts had not been sufficiently rewarded.

> *I've kept my mouth shut and engaged. I have been on the shop floor so you can write notes about me* (John, service user)

Here John verbalised his understanding of a tacit psychological contract with his clinical team. This verbalisation of a performance of compliance did not acknowledge the transformational requirement of the institution and as he had been deliberately deceptive, he might in fact be a higher risk to the public than he first appeared. In this way behaviour was pathologised in terms of risk and used to continue detention.

The regulation of communication provided an opportunity for service users to manage their risk status and promote their progression towards discharge. However, the demonstration of compliant behaviour by service users was not always be trusted by clinicians, which presented a problem for determining risk status. In the example below, during a ward round, Callum, a doctor openly voiced his concerns with the evidence underpinning a risk assessment.

> *Insight is interesting; won't kill anyone again, might stab someone, might throw a cup of boiling water but not the whole kettle! Is it cognitive?...He knows the right things to say, whether we ever get past this or…ever move on* (Callum, doctor)

Callum, identified incongruence between the service user's behaviour, emotional response and verbal responses. He did not trust that the service user had truly learnt from his past behaviour rather that he have *learnt the right things to say*. The distrust that Callum had of the service user's presentation not only resulted in a lack of progress towards discharge, but also a long term prediction that the user would never progress. Therefore the stakes were high for service users who played the game. To play the game poorly and be caught out might further hamper progress through the development of distrust in the clinical team which then had to be overcome before any further progress may be made. Their risk status not only increased, but it also became more difficult for them to reduce their risk status in the future.

Discussion

In this article we have highlighted how service users felt unable to work with formal processes to manage risk and so might *play the game* to attempt to improve their risk ratings. Through incorporating dissatisfaction with care into frameworks for risk assessment communication of frustration and dissatisfaction by service users became stifled and the information needed for effective assessment could be hidden, and problems left unresolved. Performance of compliance by service users could conflict with identities held by service users and become a barrier to partnership working.

Service users tended to quietly question the logic of systems of risk assessment and service providers were complicit in service users' games of restricting communication and demonstrating compliance, but neither group was able to challenge the system. However, it must be acknowledged that this study took place in only one medium secure unit, and so reflects the unique ecology of that unit. However, there is a paucity of research on informal processes of risk management in forensic mental health settings. Therefore we see this article as a contribution to a greater understanding of risk assessment and management in forensic mental health and also be relevant to other secure services.

In this article we have shown that forensic mental health services continue to have many of the elements of the total institutions as described by Goffman (1961). Despite being physically located within the community, service users remained distanced from the local population by high walls, systems of surveillance which brought with it social stigma. Far from being active agents who chose to engage with the processes of self-reinvention (Scott 2010), forensic mental health service users did not find themselves in an organisation where they were the informed consumers who chose to accept treatment with the aim of achieving empowerment or self-actualisation. The users in our study were subject to the involuntary physical containment of the total institution which controlled access to personal possessions, time and space to undertake activities (most notably smoking). Like Goffman's inmates the

users in our study had to c to make themselves available for surveillance and adhere to institutional rules and routines which were imposed upon them.

In this article we have shown that forensic mental health service users did demonstrate active management of their risk status, representing 21st century version of 'agentic inmates' within Goffman's *Asylums* (Scott 2010; Goffman 1961). Service users in our study resisted conversion; avoiding the adoption of the official view of their self and instead demonstrating compliance through actively managing the information flow for risk assessment, thus subverting the system of risk assessment and the very premise of forensic mental health services. However in contrast to Goffman's asylums, present day forensic mental health care are informed by the concept of recovery and an expectation of safe discharge and reintegration back to the community.

Risk assessment and management as a therapeutic endeavour is flawed as reliable indicators of risk are static, which conflicts with this change in identity. A focus on compliance rather than transformation enables the service to achieve its mission and demonstrate safe movement of users through the system from high risk patients in secure wards to the discharge of compliant users available for surveillance back in the community. Thus risk, has become overlaid with compliance, and with it there has been a subversion of the service providers' attempts to assess risk, in actuarial terms.

The service user in our study described how they demonstrated their compliance and reduced the flow of information indicative of risk. In so doing they concealed and did not resolve difficulties and frustrations, which might then affect their mental health and risk status. Service providers were apparently complicit in service users' *game playing*. Playing the game was a tacit part of the culture of the forensic mental health service. However, despite this culture, inconsistencies by service users playing the game resulted in distrust and a

higher risk status, thus providing penalties for playing the game badly and showing overt resistance to the official organisational systems of risk assessment.

In this way the institutional risk framework conflicted with the current recovery and personalisation agenda in which service users were being afforded greater choice and control to direct their recovery and social inclusion (Bonney and Stickley 2008). Rather than working in partnership with providers to recover a meaningful life and identity, the forensic mental health service users in our study fostered a duplicitous relationship with providers in which the acted like compliant patients, but maintained a secret concealed community identity (Coffey 2011). Service user participants maintained this identity through underground meetings outside of working performance hours and through remembering and restating complaints, which they felt they would be able to address once discharged back to the community.

Despite movement towards partnership working with service users, within forensic mental health services based on treatment and control (Dallaire et al 2000) the power imbalance may be too great for a true recovery based partnership to take place. However a move may be made towards self-regulation in which there is an open dialogue regarding the management of risk behaviours, and an acceptance that a transformation to a good patient or compliant citizen may never truly take place.

Conclusion

Service users' performance of compliance designed to satisfy the requirements of insitutional risk assessment may act to conceal risk indicators and that service providers are not aware of potential risks and problems faced by service users. The skills developed by service users to adapt to the ecology of a forensic mental health service through tolerating their frustrations and demonstrating compliance are unlikely to be useful when they are discharged back to live

in the community. Furthermore through secretively maintaining their community identity which existed prior to submission, service users may not address their offending behaviour or identity as an offender.

Greater consideration needs to be given to how forensic mental health service providers can work in partnership with service users to assess and manage risk so that they may enable the service to user to recover a meaningful role which is valued by society.

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