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“You Should Just Keep Your Mouth Shut and Do As We Say”: Forensic Psychiatric Inpatients’ Experiences of Risk Assessments

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ABSTRACT



This study presents findings of forensic inpatients’ experiences of their role in the risk assessment process. Eleven patients, recruited from two forensic psychiatric clinics in Sweden, participated in semi-structured interviews which were analyzed using qualitative content analysis. The analysis of their experiences resulted in the information of three categories: Taking responsibility for one’s own situation, in terms of taking responsibility for aspects of one’s care, taking charge of the present, emphasizing potential challenges in grasping reality, and being involved and having impact, which concerns feelings of being involved in discussions related to one’s care and treatment versus feelings of being an outsider.

Introduction

Studies of patient experiences of compulsory treatment generally exclude patients in forensic psychiatric care (e.g., Katsakou & Priebe, 2007; Wyder et al., 2016), although, patients’ responsibility for their involvement in their own care has been receiving increasing attention in general (Roaldset & Bjorkly, 2010). As forensic psychiatric settings deal with the task of compulsory treatment aimed at reducing the risk of criminal recidivism while taking societal protection into consideration, ethical issues regarding patients’ autonomy and their ability to participate in their treatment plans has come to the forefront of the contemporary discussion (Olausson et al., 2019). Forensic psychiatric care in Sweden assumes incarceration for persons who have committed a criminal act due to the influence of a severe mental disorder. The purpose of forensic psychiatric treatment is to prevent future violent behavior; this involves continuously assessing the risk thereof and evaluating patients’ readiness to return to society with this risk having been reduced as much as possible. Therefore, there are frequent assessments of patients’ future risk of committing violence or exhibiting other dangerous behaviors. Structured instruments, such as the Historical Clinical Risk management (HCR-20) instrument (Douglas et al., 2013), assess the risk of violence by identifying a person’s historical, clinical, and contextual risk factors. From a patient perspective,

risk assessments are primarily connected with decisions about admission, privileges granted during stay, transfer to outpatient psychiatric care, and discharge (The National Board of Health and Welfare (Socialstyrelsen), 2004). If the forensic psychiatric treatment is combined with special court supervision (SCS), the County Administrative Court decides if the care must continue due to the high risk of recidivism or if the patient can be released every six months (SFS 1991:1129). In other words, the risk assessments are a key factor in the courts’ decision-making process.

The Swedish Health and Medical Services Act states that the health-care system must respect every patient’s autonomy and integrity (SFS 2017:30), emphasizing every patient’s ability to influence their own treatment. Current legislation of patient rights in psychiatric health care strongly stresses the concept of patient participation in all parts of their care. This is in line with the person centered strive in psychiatric care in terms of placing the patient’s recourses in the foreground during treatment, and at the same time focus on identifying aspects that restrain an increase in psychiatric illness. The caregiver should provide support, help the patients to reflect on their own actions and beliefs in relation to their ability to live an independent life (Gustafsson et al., 2012), and motivate them to refrain from criminal behavior (The National Board of Forensic Medicine (RMV) report 2000:1, 2000).

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Understanding patients' subjective experiences is a central element in health-related research. In line with the person-centered perspective the importance of knowing the person behind the patient is essential. Listening to the patient's personal story acquires knowledge about the person; relating to them as a capable human being, with physical and intellectual abilities, as well as having personal and interpersonal assets (Robeyns, 2006). Furthermore, the person-centered approach emphasize to engage the patient as a partner and invite him or her to participate in care processes (Slater, 2006). The person-centered recovery process relates to Hirschi's social bonding theory (1969), which presents four interconnected bonds relating to criminality; essentially, when social bonds are lacking or impaired, the risk of deviance is increased (Durkin et al., 1999). The four bonds are attachment, referring to emotional and social ties to others that can control behavior in the sense of not wanting to disappoint emotionally important people, commitment, referring to the investment in society that people do not want to jeopardize through deviance; involvement, which assumes that spending time in prosocial activities decreases the likelihoods of engaging in criminal acts, and belief, which refers to values associated with the acceptance of social norms and behaviors that conform to the law (Pratt et al., 2011), including morally binding societal rules (Durkin et al., 1999).

Despite the formal importance of risk assessment in forensic psychiatric care in terms of inviting the patient to participate in the process, insight and knowledge are lacking in terms how patients actually perceive risk assessments. This is in contrast to the knowledge of when patients admitted to psychiatric care use self-reported assessments to predict their risk of committing violence and self-harm, which significantly predict violent behavior both during the psychiatric hospital stay and for the subsequent 3 months after discharge (Roaldset & Bjorkly, 2010). In addition, a significant association between self-assessment and subsequent violence has been found when psychiatric inpatients were asked to describe the chances of them committing a violent act in the near future (Lockertsen et al., 2018). On the other hand, psychiatric inpatients considered to be at a high risk of violent behavior, were not involved in their risk assessments; more surprisingly, many were not even aware of them (Langan, 2008).

Despite the fact that the importance of a patient's perspective is stressed in modern psychiatric care, findings still indicate a lack of awareness from the patients regarding the actual contents of the risk assessment (Dixon, 2012); there seems to be, "a difficult balancing act" (Shingler et al., 2018, p. 3208). This idea resembles the findings of another study exploring forensic mental health nurses' experiences of risk assessments and their use of them in care planning (Nyman et al., 2019). The risk assessments' focus on the patients' histories of violence challenged the nurses strive to establish a mutual relationship with the patient, in order to confirm the unique person behind the patient. The nurses also viewed the therapeutic alliance as crucial, though there was also a need to balance both caring and restricting actions (Nyman et al., 2019).

Specific research on forensic psychiatric patients' involvement in risk assessments remains scarce (Kroner, 2012; Langan, 2008). Deeper knowledge and understanding of the patients'

situations in connection with risk assessments during forensic psychiatric care would help caregivers in their attempts to provide person-centered care. The aim of this study was to explore how forensic psychiatric inpatients experience their role and participation in the risk assessment process.

Materials and methods

Recruitment and participants

Participants needed to have the capacity to consent to the study and to be willing to participate in the interview; a purposive sampling strategy was therefore used for recruitment. Participants were recruited from two forensic psychiatric clinics in different regions of Sweden; both have similar care mandates and patients in terms of gender, diagnoses, and criminal offenses. After obtaining approval from the management of each clinic, selected staff members (in collaboration with the team involved in the patient's care), who were well informed in advance of the study purpose and recruitment process, asked patients who met the inclusion criteria if they were interested in participating in an individual interview. The inclusion criteria were that patients must be 18 years or older and must have been under SCS for at least 6 months. The main reason for this second criterion is that patients placed under SCS are risk assessed more frequently. Patients reported by their treatment teams to have severe ongoing psychotic symptoms were excluded.

For patients who showed interest in participating, an interview time was set up in the visitor's area at the clinic. The interviews were conducted between September 2018 and March 2019.

Data collection

Data in this study came from semi-structured interviews focusing on the patient's experiences of risk assessments. The interview guide included eight open-ended questions, including, "Can you tell me what you know about risk assessments?"; "What do you think about your own risk assessment?"; "What pros and cons of risk assessments can you identify?"; and, "What does it mean to you to be motivated?" They were elaborated upon as needed. Eleven interviews were carried out with patients (only one of whom was female) in ongoing inpatient forensic psychiatric treatment. Of those, seven were being treated at the clinic in the western region and four in the south region. The interviews, which lasted between 10 and 40 minutes, were conducted by the first researcher. The audio-recorded interviews were then transcribed verbatim.

Ethical considerations

This study was conducted in accordance with the principles for medical research involving human subjects outlined in the World Medical Association Declaration of Helsinki (World Medical Association, 2013) and the General Data Protection Regulation (European Union Regulation 2016/679,

2016). The study was approved by the Regional Ethical Review Board in Lund, Sweden (registration number Douglas et al., 2013/329). All participants were provided with verbal and written information about the study. As the participants were undergoing compulsory treatment, they were in a state of dependence, which could potentially make them vulnerable to demands to participate. Thus, special care was taken to ensure that they did not feel pressured in that respect; they were informed that their participation was voluntary and that they could withdraw at any time without explanation or consequences. They were also assured that the data would remain confidential and that their names would be replaced with codes. It was also explained that the data would be interpreted comprehensively and that the results would be presented without identifying any individual informant. The interviewer also needed to take care not to pressure an informant if they showed reluctance or discomfort. All participants gave informed consent to participate in the study.

Data analysis

We conducted a qualitative content analysis with an inductive approach (Graneheim & Lundman, 2004). This is an often-used approach when the goal is obtaining insight into a variety of experiences and personal views. We began the analysis by reading the transcribed interviews several times. Meaning units, containing aspects related to individual experiences of risk assessments, were identified, condensed, and then labeled with a code. These codes were then sorted into emerging categories, which were reviewed and refined to ensure that the coded meaning units were relevant to each category. This deepened the analysis to a more latent level by abstracting the data through categories (Graneheim et al., 2017). The analysis implied a continuous process of forward and backward movement between the text as a whole and its parts (Graneheim & Lundman, 2004). To ensure trustworthiness, the researchers discussed the findings through the analysis process until consensus was reached. It is possible that the first researcher's experiences with mental health nursing influenced the findings. However, this pre-understanding was balanced by having two researchers analyzing the data and participating in discussions during the process (Graneheim & Lundman, 2004). All four researchers agreed with the final results. The analysis was performed using the qualitative software NVivo 12.

Findings

The patients' experiences of and reflections surrounding their role and participation in the risk assessment process could be summarized in the following three categories: Taking responsibility for one's own situation, taking charge of the present, and being involved and having an impact. These three represent the main points analysis and are presented below along with quotes from the interviews.

Taking responsibility for one's own situation

The informants stressed the importance of being active and engaged, wanting to do the right thing, taking one's medicine, not causing any trouble on the ward, and visualizing future goals. They dreamt of future opportunities to study or to have a job after being discharged, emphasizing their willingness to contribute to society:

The goal is (author's input) to not have to live on income support and the Social Insurance Agency. I have worked before so... yeah, absolutely. To pay taxes and pay the rent. Then nobody can say to you, "do this, do that" you know? And you are contributing, and you are occupied during the days and are able to meet new people at work and so on. (Informant 9)

It means a lot because it is my future. I need to know about everything that goes on around me: my finances, my well-being, occupation, friends, family, medication, and conversations with the psychologist and the doctor. To be able to have a good future, you must be aware of what is going on. I want to succeed/.../So, I am active and motivated. (Informant 9)

The participants expressed the desire to take responsibility for their own situations by developing their own goals and staying busy, for instance by exercising, socializing, and, with permission leaving the hospital area by themselves.

This goal of taking responsibility for one's own situation was, however, dependent upon engagement from the staff. If the staff's level of engagement was high, the patients' commitment in their own care increased, which additionally raised their sense of participation. However, if the staff's engagement was not perceived as genuine or felt half-hearted (e.g., if the staff conveyed the attitude that, "this is just a job"), the patients' motivation to take responsibility in their situations faded:

One category of those [staff] who wants to do something for the society/.../. They are the best. Then there are those who do it for the salary. There is nothing to say about that. And then there are those who are just here to dominate people. (Informant 1)

The informants stressed the staff's inability to negotiate conflicting situations. Even though the informants were aware of the importance of them engaging in challenging encounters to promote their development and growth, they often chose to withdraw from these opportunities in order to avoid the risk of ending up in a situation where they could potentially not receive necessary support from staff. Their increased awareness of being constantly under observation by staff and subjected to the documentation of their actions, contributed to patients becoming cautious and distrustful:

If there is trouble and they start to make noise, then you just have to leave the place. Even if they (fellow patients) are acting correctly and so on... I think that I would not interfere. It isn't worth it. Everything will be documented. (Informant 1)

Informants feared that these situations would impact their risk assessments. Lack of structure and planning of care and a sense of a lack of sympathy created uncertainty, which, in turn affected engagement due to a sense of helplessness:

Well you feel so... you are so helpless. It is only them who decide. You kind of don't come forward. Nobody listens to you. (Informant 1)

The inexplicit goal of the care reduced the patients' motivation why the inpatient stay became a circumstance that to a large part was about 'to kill time'

However, the picture was not entirely negative; there were also some indications of confidence in the idea of the staff wanting to help due to their guidance of patients making difficult decisions. In addition, it seemed to be encouraging for them to see that the staff payed attention and was well-informed about the patients as unique persons:

But then I started to realize... that everyone who is working here is professional, you know? They know what kinds of behavior pattern I have and that makes it very personal some how. (Informant 12)

They know exactly what I have done, and well... how I feel and what I think and how I behave. So it's good for me. (Informant 12)

Taking charge of the present

Taking charge of the present was characterized by challenges in grasping reality versus experiencing feelings of uncertainty. For example, when the time for a court hearing approached, as does every six months, (i.e., a process similar to what is found in a review board where decisions about the care are taken), patients would receive documents describing their history of illness and, crime, treatment process, and assessed risk of violent behavior. These documents were often difficult to understand due to unfamiliar 'medical language'; patients therefore became frustrated when they did not understand the reason behind a suddenly changed diagnosis, for instance:

It is the same with my ADHD./.../. It is chronic. You learn how to deal with it, more or less. Sometimes, new diagnoses appear. And then they disappear at the next court proceedings. That feels weird. (Informant 2)

One informant gave the following description when asked if they had studied the content of their risk assessment: "I got lots of papers, I don't know. I didn't read them. I don't understand what they say," (Informant 3). Additionally, experiences of not being properly informed about important decisions, such as involuntary trusteeship, were mentioned, as well as a sense of concealment of contents related to the risk assessment, leading to a sense of impotence: "No, you don't talk about it (risk assessment). It's something that they are hush-hush about in the [staff] group," (Informant 4).

Taking charge of the present was also related to worries about the influence of the past. The past was mentioned as something that could create doubts about one's current abilities and capabilities; one example could be a previous substance abuse problem. The informants also feared that their past offenses would become obstacles that would limit their futures and affect their self-esteem regardless of how long ago they were:

Because you don't want to think about the past. But when we do the risk assessment, they put together everything and then you feel like a bad person every time they mention that you have committed an aggravated assault and violence against a public servant. (Informant 9)

Another influencing factor was the indeterminate amounts of time in custody, resulting in comparisons with prison. Patients described forensic psychiatric care as a repository where forensic mental health patients were kept in passivity. They also referred to a prison sentence as an advantage in terms of having a fixed date for when the incarceration would end. The statement, "I have been locked up for a long time," was common, and it was often followed by the idea that a prison sentence would have taken much less time. The treatment period was regarded as lengthy and the lack of awareness of how long it would take to reach specific care objectives was disturbing and lead to feelings of resignation and hopelessness. Experiences of being restrained and even punished upon failure to cooperate was stated: "You should just say thanks and accept it and if you cause trouble or do something against the doctor or contradict them, then they will withdraw and threaten you in one way or another," (Informant 4). Nevertheless, receiving forensic psychiatric care was preferable for some in the sense that it included better planning for post-treatment care:

It can take a very long time as well, as compared to prison time, but then you end up on the street and have to live at a shelter and you start to take drugs again and go back to prison. It is more humane in institutional care. (Informant 12)

Difficulties in *taking charge of the present* were mostly due to conflicting and confusing information, especially in terms of the care process. In addition, being informed of a high assessed risk level despite taking prescribed medication, feeling well, and never causing any trouble increased feelings of not grasping reality, and, in a deeper sense, not being viewed as a person able to handle themselves:

Yeah I can say that I committed that crime when I wasn't feeling well. But now I am in a completely different state of health so I am not posing any risk, not for you or the staff inside. I haven't threatened and I haven't quarreled. I haven't done anything to anyone. I don't know... for them we are still [seen as] dangerous. For the doctor, for the staff. (Informant 4)

Care was described as insufficient and the lack of explanation for delayed processes resulted in feelings of anxiety and frustration; care was even compared to storage. A sense of being punished when behaving well, being transferred to another ward due to organizational issues (e.g., lack of rooms), for instance, was also mentioned.

In the patients' opinion there were opportunities to streamline their care, for instance, by having important meetings more often, but that were not being taken since it was solely under the purview of staff. In other words, the patients themselves could not accelerate the care process. Specific issues, such as lack of housing on the outside, further affected length of stay. Additionally, the six-month gap between court proceedings was regarded as too long. However, not all the patients had difficulty with grasping the present. Some expressed that the length of the stay could be useful for developing interests and hobbies:

Everything is perfect, you know, because I make use of the time here, you know. I think, "Well I am here. Very good. Happy. Then I have to work with myself". (Informant 10)

Being involved and having an impact

Being involved and having an impact concerns the extent to which the patients feel that they are taking part in or influencing discussions related to their care and treatment, which could be directly or indirectly related to their risk assessment. The interviewees emphasized structured conversations with the staff as important to shared decision-making. Participating in care planning, to them, meant being invited to structured meetings with the care team and presenting opinions as well as reflections on what had been good or bad in the last week or month. However, feelings of exclusion impacted shared decision-making in that wishes and proposals were not always taken into consideration and denied requests were not always explained. Furthermore, lack of pre-information about meetings as well as having meetings too rare hindered shared decision-making. The possibility of changing their own circumstances felt limited, especially since opposing the staff could lead to negative consequences, creating feelings of powerlessness. There were also some patients who emphasized that asking questions disliked:

You have to give in, “We decide. You should just keep your mouth shut and do as we say.” It is like that. You can’t describe it in another way. Well, they put demands on you because they want you to give in and give up. Just keep saying, “Yes, yes, yes.” Otherwise, you won’t be given any permission to leave. (Informant 4)

The patients’ level of involvement in the risk assessment process emphasized contradictory experiences. Some informants felt very familiar with the process; they had a clear picture of it, feeling involved both in the process and the feedback, and felt that they understood the meaning of risk factors in relation to their own circumstances:

It (risk assessment, authors’ input) says something about what you have done before when you were staying here inside: why you were arrested; some history too, at younger ages and about what has happened. Then they make decisions about certain things. (Informant 5)

There were even some benefits associated with risk assessments:

Risk assessments... focus on when you are being released as well. So you won’t be just set free. Many will probably be able to manage it when they are released, but it is easy to end up doing drugs again. When you end up doing drugs, criminality will follow. So I think it (risk assessment) is right. (Informant 5)

For some, the risk assessment process also contributed to patients’ awareness of the main factors involved in their care. Others, on the contrary, did not know how the assessments were performed or by whom. Informants also described risk assessments as an expression of patients’ behavior on the ward. Some felt that risk factors were never discussed. Awareness of their individual risk levels was generally high, but awareness of the reasoning behind them seemed to be low or even absent; several did not know how the risk assessments were performed or by whom: “But I don’t know how they are carried out, in practice,” (Informant 8). The risk assessment seemed strongly connected to the court proceedings, as the assessments were

mostly brought to the forefront in time for these proceedings to take place. Some expressed that neither their risk factors or risk of recidivism nor their protective factors were ever discussed.

Factors that informants mentioned as supportive were family and housing, having some meaningful activity to do, and staying away from old friends. Even hospital stays were seen as a supportive factor—being actually “locked in.” The common opinion, however, was that there was a greater focus, in general, on risks than on protective factors. Risk factors, commonly received as negative, clearly overruled protective (positive) factors.

Being involved and having impact was also characterized by a feeling of not being able to participate, being excluded from decision-making, and having a sense of “me and them.” This was illustrated, for example, when participating in meetings and suddenly being told to leave the room when decisions were made, or when attending court proceedings every six months feeling that no one was actually interested in their feelings or opinions. Additionally, being in an environment with high walls, wire fences, and restrictions on moving freely inside the buildings emphasized segregation. There was sense of societal stigma, of being regarded as a dangerous person and, consequently, experiencing an obstacle when returning to society in terms of employment or housing:

It feels like you have a sentence for life and will be marked for the rest of your life. And people out there don’t know how it is in forensic psychiatric hospitals, to be here. They think that we are dead dangerous. Some of them think that we are dead dangerous psychopaths, like child molesters or rapists, and so on... But that’s not right. (Informant 9)

Some of the informants felt that their insufficient participation was unfair and that the unequal balance of power lead to a lack of motivation, lack of understanding, and incapability to change or influence their situation. The only way for them to proceed was to accept decisions and adjust to their outcomes; for example, being forced to accept a care giver companion in order to get permission to leave the hospital area. Deprivation of adulthood was mentioned and comparisons were made with nursery school; overall, internal surveillance in the care system contributed to the sense of powerlessness.

Discussion

The aim of this study was to illuminate forensic psychiatric inpatients’ experiences of risk assessments. However, the informants’ statements revealed an overall unawareness and lack of understanding of the risk assessment process as an entity, which complicated their ability to reflect on the importance of the risk assessment process as a tool in their recovery. This struggle is manifested in the findings in terms of the ideas of taking responsibility for their situation, taking charge of the present, and being involved and having an impact.

Over the past several decades, there has been a great focus on recovery-oriented care in the area of mental health

in terms of both psychiatry and forensic psychiatry (McKeown et al., 2016; Nijdam-Jones et al., 2015). The necessary components for recovery have been identified in terms of involvement in programs, belief in rules and social norms, attachment to supportive individuals, commitment to work-related activities, and concern about indeterminacy of stay (Nijdam-Jones et al., 2015). These components are very similar to Hirschi's (1969) four elements of pro-social bonds, attachment, commitment, involvement, and beliefs, which, according to his conception, are inversely related to the development of criminal behavior. Simply put, low occurrences of these qualities work as driving forces on individuals' propensity for criminal activity (Pratt et al., 2011). This study's findings also show parallels to the social bonding theory in relation to the patients' sense of taking responsibility for their own situations. This encompasses both the patient's responsibility for their own engagement and their perception of the staff's level of commitment to their care as a combination of genuine engagement and reliance on the staff's true intentions. In other words, a feeling of trust, from the patients' perspective, seemed to be a prerequisite in the risk assessment process. This is similar to findings from a secure setting in UK, where the service users' level of satisfaction with care was associated with their therapeutic relationships with staff (Bressington et al., 2011). The importance of a trusting relationship with staff was also stressed among inpatients in a medium secure forensic setting when offering their perspectives on rehabilitation (Barnao et al., 2015) and their satisfaction with care in forensic mental health settings (MacInnes et al., 2014). This also connects to findings from mental health nurses that stress the importance of establishing a trusting relationship with patients as a crucial factor of the risk assessment process (Nyman et al., 2019). The trusting relationship was formulated in terms of keeping the patient informed and prepared before meetings which in turn, was assessed as crucial for ensuring involvement and awareness of the arguments related to the patients' risk assessments (Nyman et al., 2019).

Furthermore, the patients' emphasis on the importance of motivation in terms of thinking about their future and their willingness to contribute to society connects to the social bond theory (Hirschi, 1969). This internal perception of being subjected to the norms and rules of society is crucial to Hirschi's belief. Furthermore, Hirschi's commitment fits well with the informants' desire to take responsibility by behaving well and being compliant, which can be interpreted as beneficial investments in a relationship with the staff that, in turn, supports recovery (Coffey et al., 2017). This is similar to findings from studies on forensic psychiatric patients' experiences of their journey toward recovery while moving from the turning point phase to the recovery phase (Olsson et al., 2014). The importance of acknowledging internal engagement with the treatment is stressed (Sainsbury et al., 2004), as is awareness of increased feelings of hope and optimism about the future and being able to contribute to society (Livingston, 2018). Findings like those mentioned here, as well as the present study, point to the

importance of involving the patient in their own care process whenever their engagement is a crucial to the care outcome.

Another key finding of this study indicates that forensic inpatients faced difficulties in taking charge of the present, which manifested in an inability to grasp the risks associated with themselves. This is in line with findings of high awareness among forensic patients about the risk assessment *per se*, but low awareness of its contents (Dixon, 2012). Our study also clarified that patients found it difficult to grasp the whole picture of the risk assessment due to significant focus on their risk factors and less emphasis on their resources. This is in contrast with recommendations that show the benefits derived from focusing on protective factors as well as risk factors during risk assessments (Kashiwagi et al., 2018), suggesting that protective factors should be integrated into risk assessments to give a more comprehensive picture of the patient's risk of committing violence (Abbiati et al., 2017). Difficulties in taking charge of the present were also connected to receiving insufficient information about aspects of the risk assessment. This is in line with findings from a previous study of restrictive phenomena, where psychiatric inpatients in a secure hospital in England experienced stigmatization, limitations of their agency, restricted autonomy of movement, prohibitions of different kinds, and lack of information about their care (Tomlin et al., 2020).

Comparison to prison stay was another contributing factor to being unable to grasp reality in our study, which is in line with other studies (Tomlin et al., 2020) in terms of the fact that the actual length of incarceration can be much longer in forensic psychiatric treatment as compared to a fixed prison sentence of someone without a severe mental disorder who committed the same crime. There is an ethical dilemma associated with an unlimited length of stay and its connection to the estimated risk of future violence, which has been discussed in terms of increased uncertainty and difficulties in grasping reality (Adshead, 2000). The dilemma lies in the question of preventive incarceration—in other words, “/.../the detention of patients who might be dangerous in the future for the safety and/or the benefit of others,” (Adshead, 2000, p. 303).

Growing attention on user involvement (Eidhammer et al., 2014), including its addition to the legislation (SFS 2014:821), should encourage forensic psychiatric caregivers to involve patients in all aspects of their care, despite its involuntary nature. In our study, possibilities of being involved in shared decision-making were hampered, affecting patients' opportunities to change their situations. Additionally, the finding related to restraint as a consequence of concern about the staff's reactions has been stressed before in terms of the patients “playing the game” and complying with treatment in hopes of improving their risk ratings as a consequence of dissatisfaction with risk assessment-related care (Reynolds et al., 2014).

However, our findings show inconsistency in that some patients felt involved with their risk assessments and some did not. Insufficient or lack of involvement increased

patients' feelings of being an outsider, which, according to Hirschi's element belief, can negatively affect the social bond. The influence of the stigma that forensic psychiatric patients bear is emphasized in the literature (Adshhead, 2000), and has also been investigated in an intervention study where the forensic psychiatric patients despite an investigation that intended to promote the patients' engagement only demonstrated a scarce affect, even though their experiences of the care improved (Livingston et al., 2013).

The importance of shared decision-making and its applicability to involuntary psychiatric settings has been studied (Hamann et al., 2003), showing a relationship between a higher level of patient involvement and fewer re-hospitalizations; this is further supported by the findings of Hamann et al. (2007). Contrasting findings have also been presented, such as lack of transparency in terms of insufficient explanations of denied requests as well as decisions concerning risk management (Sustere & Tarpey, 2019). This is in line with our study, in which patients participated by taking part in meetings and having conversations with the staff while simultaneously expressing a lack of knowledge of the content of risk assessments, exacerbating their feelings of being an outsider.

Studies indicate the benefits of future patient involvement in risk assessments; results have shown that letting patients estimate their own risks has resulted in more accurate predictions of violence (Skeem et al., 2013) if patient inclusion is complemented by proper education about the process and invitations to regular meetings in which the risk assessment and formulations of risk scenarios are carried out. The results must then be summarized in a way that the patient can understand (Horstead & Cree, 2013). Additionally, risk assessments have been highlighted as not being used often in collaboration with patients, which may present an obstacle to recovery, as the patient is then unaware of what is actually keeping them incarcerated and what they should do to progress, which may contribute to a lack of responsibility (Mann et al., 2014). Lack of transparency in the risk assessment process may also increase the risk of making the patient feel left out of their own risk management, leading to resentment.

Limitations

Those who worked most closely with the patients were the ones who told them about the study and asked about their willingness to participate. This approach affected the selection, but it probably provided the richest possible data because the patients were approached by people who knew them well.

Participants may have felt cautious in terms of sharing sensitive aspects of their experiences and views, although it appeared that they generally communicated honestly and to the best of their ability with a good balance of positive and negative views, leading to a large amount of complex and multifaceted data. There was an imbalance regarding gender representation, as only one female patient participated in the study, although this merely reflects the real gender imbalance in forensic psychiatric care populations.

Relevance in clinical practice

The results of the present study have some important implications for practice. The benefits of increasing forensic psychiatric patients' opportunities for involvement and understanding of their own risk assessment processes may enable these patients to obtain a more comprehensive view of their care and increase their awareness of both their protective factors and their risk factors. In the long run, this may strengthen their feelings of personal responsibility and create opportunities for them to develop a sense of ownership and understanding of their care. This, in turn, may increase their autonomy helping them influence and play an active role in their recovery.

In addition, forensic psychiatric patients are probably more capable of participating in their own risk assessments than expected; this knowledge could uncover additional valuable aspects of individual risk factors and protective factors. Including patients in the risk assessment process from the beginning may provide a more comprehensive and valid risk assessment and more sustainable risk management.

Our findings also indicate a need for access to correct and understandable information. The limit of patients' understanding of and, involvement in the risk assessment process has been stressed; this may lead to hampered collaboration due to a sense of mistrust, a denial of risk factors, and negative effects on the therapeutic alliance (Horstead & Cree, 2013).

Conclusion

This study highlighted forensic psychiatric inpatients' experiences of risk assessment; this is—a population that is rarely heard in research concerning risk assessment and risk management (Markham, 2018). The findings offer valuable insight into their perspectives and highlight their attempts to take an active part in their care and their desire to take responsibility for their care. These goals can be met by the caregivers, who generally have the ability to clarify the reasons behind decisions and relate them to risk assessment results. One way to do this is to regularly invite patients into dialogues focused on self-perceived individual risk factors and ways to cope with them.

Forensic psychiatric patients are a vulnerable group in several ways; they are a large part of society's most under-resourced and disabled individuals. It is, therefore, important to promote agency and active participation in their own care processes, highlighting the most important conditions for autonomy and well-being.

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References

- Abbiati, M., Azzola, A., Palix, J., Gasser, J., & Moulin, V. (2017). Validity and predictive accuracy of the structured assessment of protective factors for violence risk in criminal forensic evaluations – A Swiss cross-validation retrospective study. *Criminal Justice and Behavior*, 44(4), 493–510. <https://doi.org/10.1177/0093854816677565>
- Adsheed, G. (2000). Care or custody? Ethical dilemmas in forensic psychiatry. *Journal of Medical Ethics*, 26(5), 302–304. <https://doi.org/10.1136/jme.26.5.302>
- Barnao, M., Ward, T., & Casey, S. (2015). Looking beyond the illness: Forensic service users' perceptions of rehabilitation. *Journal of Interpersonal Violence*, 30(6), 1025–1045. <https://doi.org/10.1177/0886260514539764>
- Bressington, D., Stewart, B., Beer, D., & MacInnes, D. (2011). Levels of service user satisfaction in secure settings—a survey of the association between perceived social climate, perceived therapeutic relationship and satisfaction with forensic services. *International Journal of Nursing Studies*, 48(11), 1349–1356. <https://doi.org/10.1016/j.ijnurstu.2011.05.011>
- Coffey, M., Cohen, R., Faulkner, A., Hannigan, B., Simpson, A., & Barlow, S. (2017). Ordinary risks and accepted fictions: How contrasting and competing priorities work in risk assessment and mental health care planning. *Health Expectations*, 20(3), 471–483. <https://doi.org/10.1111/hex.12474>
- Dixon, J. (2012). Mentally disordered offenders' views of "their" risk assessment and management plans. *Health, Risk & Society*, 14(7–8), 667–680. <https://doi.org/10.1080/13698575.2012.720965>
- Douglas, K. S., Hart, S. D., Webster, C. D., & Belfrage, H. (2013). *HCR-20 (version 3): Assessing risk for violence*. Mental Health, Law, and Policy Institute, Simon Fraser University.
- Durkin, K. F., Wolfe, T. W., & Clark, G. (1999). Social bond theory and binge drinking among college students: A multivariate analysis. *College Student Journal*, 33, 450–461.
- Eidhammer, G., Flutert, F., & Björkly, S. (2014). User involvement in structured violence risk management within forensic mental health facilities – A systematic literature review. *Journal of Clinical Nursing*, 23(19–20), 2716–2724. <https://doi.org/10.1111/jocn.12571>
- European Union Regulation 2016/679. (2016). 2016/679. *GDPR regulation on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, and repealing Directive 95/46/EC repealing Directive 95/46/EC*. Retrieved July 21, 2021, from <https://op.europa.eu/sv/publication-detail/-/publication/n3e485e15-11bd-11e6-ba9a-01aa75ed71a1/language-en>.
- Graneheim, U. H., Lindgren, B.-M., & Lundman, B. (2017). Methodological challenges in qualitative content analysis: A discussion paper. *Nurse Education Today*, 56, 29–34. <https://doi.org/10.1016/j.nedt.2017.06.002>
- Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts, procedures, and measures to achieve trustworthiness. *Nurse Education Today*, 24(2), 105–112. <https://doi.org/10.1016/j.nedt.2003.10.001>
- Gustafsson, E., Holm, M., & Flensner, G. (2012). Rehabilitation between institutional and non-institutional forensic psychiatric care: Important influences on the transition process. *Journal of Psychiatric and Mental Health Nursing*, 19(8), 729–737. <https://doi.org/10.1111/j.1365-2850.2011.01852.x>
- Hamann, J., Cohen, R., Leucht, S., Busch, R., & Kissling, W. (2007). Shared decision making and long-term outcome in schizophrenia treatment. *The Journal of Clinical Psychiatry*, 68(07), 992–997. <https://doi.org/10.4088/JCP.v68n0703>
- Hamann, J., Leucht, S., & Kissling, W. (2003). Shared decision making in psychiatry. *Acta Psychiatrica Scandinavica*, 107(6), 403–409. <https://doi.org/10.1034/j.1600-0447.2003.00130.x>
- Hirschi, T. (1969). *Causes of delinquency*. University of California Press.
- Horstead, A., & Cree, A. (2013). Achieving transparency in forensic risk assessment: A multimodal approach. *Advances in Psychiatric Treatment*, 19(5), 351–357. <https://doi.org/10.1192/apt.bp.112.010645>
- Kashiwagi, H., Kikuchi, A., Koyama, M., Saito, D., & Hirabayashi, N. (2018). Strength-based assessment for future violence risk: A retrospective validation study of the structured assessment of protective factors for violence risk (SAPROF), Japanese version, in forensic psychiatric inpatients. *Annals of General Psychiatry*, 17(1), 1–8. <https://doi.org/10.1186/s12991-018-0175-5>
- Katsakou, C., & Priebe, S. (2007). Patient's experiences of involuntary hospital admission and treatment: A review of qualitative studies. *Epidemiologia e Psichiatria Sociale*, 16(2), 172–178. <https://doi.org/10.1017/S1121189X00004802>
- Kroner, D. G. (2012). Service user involvement in risk assessment and management: The transition inventory. *Criminal Behaviour and Mental Health: CBMH*, 22(2), 136–147. <https://doi.org/10.1002/cbm.1825>
- Langan, J. (2008). Involving mental health service users considered to pose a risk to other people in risk assessment. *Journal of Mental Health*, 17(5), 471–481. <https://doi.org/10.1080/09638230701505848>
- Livingston, J. D. (2018). What does success look like in the forensic mental health system? Perspectives of service users and service providers. *International Journal of Offender Therapy and Comparative Criminology*, 62(1), 208–228. <https://doi.org/10.1177/0306624X16639973>
- Livingston, J. D., Nijdam-Jones, A., Lapsley, S., Calderwood, C., & Brink, J. (2013). Supporting recovery by improving patient engagement in a forensic mental health hospital: Results from a demonstration project. *Journal of the American Psychiatric Nurses Association*, 19(3), 132–145. <https://doi.org/10.1177/1078390313489730>
- Lockertsen, Ø., Procter, N., Vatnar, S., Faerden, A., Eriksen, B., Roaldset, J., & Varvin, S. (2018). Screening for risk of violence using service users' self-perceptions: A prospective study from an acute mental health unit. *International Journal of Mental Health Nursing*, 27(3), 1055–1065. <https://doi.org/10.1111/inm.12413>
- MacInnes, D., Courtney, H., Flanagan, T., Bressington, D., & Beer, D. (2014). A cross sectional survey examining the association between therapeutic relationships and service user satisfaction in forensic mental health settings. *BMC Research Notes*, 7, 657. <https://doi.org/10.1186/1756-0500-7-657>
- Mann, B., Matias, E., & Allen, J. (2014). Recovery in forensic services: Facing the challenge. *Advances in Psychiatric Treatment*, 20(2), 125–131. <https://doi.org/10.1192/apt.bp.113.011403>
- Markham, S. (2018). Red-teaming the panopticon (mobilizing adaptive change in secure and forensic settings). *The Journal of Forensic Psychiatry & Psychology*, 29(1), 16–36. <https://doi.org/10.1080/14789949.2017.1335761>
- McKeown, M., Jones, F., Foy, P., Wright, K., Paxton, T., & Blackmon, M. (2016). Looking back, looking forward: Recovery journeys in a high secure hospital. *International Journal of Mental Health Nursing*, 25(3), 234–242. <https://doi.org/10.1111/inm.12204>
- Nijdam-Jones, A., Livingston, J. D., Verdun-Jones, S., & Brink, J. (2015). Using social bonding theory to examine 'recovery' in a forensic mental health hospital: A qualitative study. *Criminal Behaviour and Mental Health*, 25(3), 157–168. <https://doi.org/10.1002/cbm.1918>
- Nyman, M., Hofvander, B., Nilsson, T., & Wijk, H. (2019). MentaMental health nurses' experiences of risk assessments for care planning in forensic psychiatry. *International Journal of*

- Forensic Mental Health*, 19(2), 103–113. <https://doi.org/10.1080/14999013.2019.1646356>
- Olausson, S., Danielson, E., Berglund Johansson, I., & Wijk, H. (2019). The meanings of place and space in forensic psychiatric care – A qualitative study reflecting patients' point of view. *International Journal of Mental Health Nursing*, 28(2), 516–526. <https://doi.org/10.1111/inm.12557>
- Olsson, H., Strand, S., & Kristiansen, L. (2014). Reaching a turning point-how patients in forensic care describe trajectories of recovery. *Scandinavian Journal of Caring Sciences*, 28(3), 505–514. <https://doi.org/10.1111/scs.12075>
- Pratt, T. C., Gau, J. M., & Franklin, T. W. (2011). Key idea: Hirschi's social bond/social control theory. In T. C. Pratt, J. M. Gau, & T. W. Franklin (Eds.), *Key ideas in criminology and criminal justice* (pp. 55–69). Sage Publications.
- Reynolds, L. M., Jones, J. C., Davies, J. P., Freeth, D., & Heyman, B. (2014). Playing the game: Service users' management of risk status in a UK medium secure forensic mental health service. *Health, Risk & Society*, 16(3), 199–209. <https://doi.org/10.1080/13698575.2014.911820>
- Roaldset, J. O., & Bjorkly, S. (2010). Patients' own statements of their future risk for violent and self-harm behaviour: A prospective inpatient and post-discharge follow-up study in an acute psychiatric unit. *Psychiatry Research*, 178(1), 153–159. <https://doi.org/10.1016/j.psychres.2010.04.012>
- Robeyns, I. (2006). The capability approach in practice. *Journal of Political Philosophy*, 14(3), 351–376. <https://doi.org/10.1111/j.1467-9760.2006.00263.x>
- Sainsbury, L., Krishnan, G., & Evans, C. (2004). Motivating factors for male forensic patients with personality disorder. *Criminal Behaviour and Mental Health: CBMH*, 14(1), 29–38. <https://doi.org/10.1002/cbm.558>
- SFS 1991:1129. *Lag om rättspsykiatrisk vård (The Forensic Mental Care Act. Swedish Codes of Statues)*. <https://rkrattsbaser.gov.se/sfs?bet=1991:1129>
- SFS 2014:821. *Patientlag (Patient Law. Swedish Codes of Statues)*. <https://rkrattsbaser.gov.se/sfst?bet=2014:821>
- SFS 2017:30. *Hälsa-och sjukvårdslagen (Health and Medical Services Act. Swedish Codes of Statues)*. <https://rkrattsbaser.gov.se/sfs?bet=2017:30>
- Shingler, J., Sonnenberg, S., & Needs, A. (2018). Risk assessment interviews: Exploring the perspectives of psychologists and indeterminate sentenced prisoners in the United Kingdom. *International Journal of Offender Therapy and Comparative Criminology*, 62(10), 3201–3224. <https://doi.org/10.1177/0306624X17739211>
- Skeem, J., Manchak, S., Lidz, C., & Mulvey, E. (2013). The utility of patients' self-perceptions of violence risk: Consider asking the person who may know best. *Psychiatric Services (Washington, D.C.)*, 64(5), 410–415. <https://doi.org/10.1176/appi.ps.001312012>
- Slater, L. (2006). Person-centredness: A concept analysis. *Contemporary Nurse*, 23(1), 135–144. <https://doi.org/10.5172/conu.2006.23.1.135>
- Sustere, E., & Tarpey, E. (2019). Least restrictive practice: Its role in patient independence and recovery. *The Journal of Forensic Psychiatry & Psychology*, 30(4), 614–629. <https://doi.org/10.1080/14789949.2019.1566489>
- The National Board of Forensic Medicine report 2000:1 (RMV rapport). (2000). *Riskbedömning vid rättspsykiatrisk undersökning – Riktlinjer och reflexioner*. Nordstedts tryckeri AB.
- The National Board of Health and Welfare (Socialstyrelsen). (2004). *Riskbedömningar inom den specialiserade psykiatriska vården – en Kartläggning (Risk assessment within the specialised psychiatric care – A survey)*. The National Board of Health and Welfare.
- Tomlin, J., Egan, V., Bartlett, P., & Völlm, B. (2020). What do patients find restrictive about forensic mental health services? A qualitative study. *International Journal of Forensic Mental Health*, 19(1), 44–56. <https://doi.org/10.1080/14999013.2019.1623955>
- World Medical Association. (2013). *WMA declaration of Helsinki: Ethical principles for medical research involving human subjects*. Retrieved July 21, 2021, from <https://www.wma.net/policies-post/wma-declaration-of-helsinki-ethical-principles-for-medical-research-involving-human-subjects/>.
- Wyder, M., Bland, R., & Crompton, D. (2016). The importance of safety, agency and control during involuntary mental health admissions. *Journal of Mental Health (Abingdon, England)*, 25(4), 338–342. <https://doi.org/10.3109/09638237.2015.1124388>