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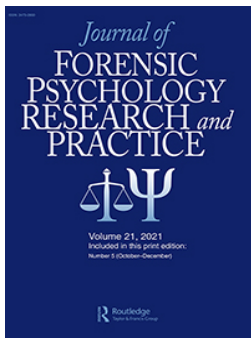
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A Qualitative Exploration of Service Users' Experiences of Violence Risk Assessment and Management in Forensic Mental Health Settings: An Interpretative Phenomenological Analysis

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ABSTRACT

Violence risk assessment and management is central to the lives of forensic mental health service users. Whilst studies have explored mental health professionals' experiences of violence risk assessment and management, research regarding service user views is largely absent from the literature. Using Interpretative Phenomenological Analysis, the current study interviewed seven forensic mental health service users in low secure mental health inpatient settings about their experiences of violence risk assessment and management. Interviews were recorded, transcribed, and analyzed. Results identified four superordinate themes; *Who is this for?*, *Power, Misunderstood*, and *Moving Forward*. The results are discussed in relation to existing literature. Clinical implications and future research directions are then considered.

KEYWORDS

Risk assessment; risk management; forensic mental health; qualitative

Introduction

Forensic mental health

Forensic mental health (FMH) services are provided for individuals who are deemed to pose a risk of violence to others, where the risk is usually related to a mental disorder (Joint Commissioning Panel for Mental Health, 2013). Violence risk assessment and management is at the forefront of the work of FMH services (Markham, 2020). FMH professionals are seen as specialists in risk assessment and management (Dixon, 2012). However, this is not the sole task of FMH professionals, as of equal importance is providing mental health-care for the individual. FMH professionals can thus be seen as having a dual role, working in the interest of the person and for the safety of the community (Van Den Brink et al., 2015). Both elements are necessary for a FMH service to function optimally (Mann et al., 2014).

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The recovery paradigm has become the dominant model in FMH in recent years (Tomlin et al., 2020). Although there is no universally accepted definition for recovery, Leamy et al. (2011) proposed a framework identifying the key elements as connectedness, hope, identity, meaning, empowerment, and spirituality. The recovery approach is seen as a strengths-based approach which involves clinicians supporting service users to lead satisfying and meaningful lives alongside mental illness (Slade et al., 2014). At the core of the approach are therapeutic relationships, active participation and developing a sense of agency over one's life (Simpson & Penney, 2011).

The concept of recovery in FMH may initially seem like a difficult fit. It would appear that recovery looks for the best in individuals and risk assessment and management can be seen as preparing for the worst (Stuart et al., 2017). While recovery is as important for forensic service users as any other service user, it can present challenges for both service users and staff, examples of which include managing therapeutic relationships in coercive settings and maintaining personal and environmental safety (Simpson & Penney, 2011). Additional factors and challenges relating to circumstances are important to consider when implementing the recovery approach in FMH. For example, in a meta-synthesis of qualitative studies, Shepherd et al. (2016) found that a sense of safety and security was seen by FMH service users as essential for recovery. This element of recovery was not apparent in the framework outlined by Leamy et al. (2011) and this likely reflects the differing experiences of those in FMH settings. Despite the apparent paradox, bridging the concepts is essential for both recovery and effective risk management (Simpson & Penney, 2011).

Risk assessment and management in forensic mental health settings

Broadly speaking there are three approaches to risk assessment and management of violence. Risk assessments can take the form of unstructured estimates of risk based on intuitive clinical experience (Markham, 2020). However, there is general agreement in the literature that this method lacks reliability, validity, and transparency (Levin, 2019). The second option is the actuarial risk assessment approach which focuses on static predictors of violence which have been found to be associated with increased risk, such as gender or acute psychiatric symptoms (Trenoweth, 2003). This approach has been criticized for focusing on static factors and risk prediction rather than guiding risk management interventions. This can be seen as unhelpful for clinicians for care planning and goes against the concept of recovery-oriented care (Levin, 2019). The third, and most widely accepted approach, is the structured professional judgment (SPJ) approach (Markham, 2020). SPJ can be seen as a binding of the unstructured clinical judgment and actuarial approaches. It integrates empirically supported risk factors with clinical judgment to produce

a judgment about potential for future violence (Chaimowitz et al., 2020). The SPJ approach supports a shift from predicting risk based on unchanging or static risk factors toward a focus on the management of risk and the prevention of violence (Simpson & Penney, 2011).

Regardless of which approach is used or the validity of the assessment made, collaborative risk assessment and management has been recommended for over a decade (Markham, 2020). This means that risk assessment and management should involve a joint decision-making process between service users and professionals. The service user should be involved in each step of the process and given the opportunity to play a central role in identifying risks and deciding the level of support they need to minimize these risks (Department of Health, 2009; Ray & Simpson, 2019; Risk Management Authority, 2016, 2018; Söderberg et al., 2020).

The positive impacts of collaboration are well recognized (Markham, 2020). Collaboration can ensure important information is not missed (Eidhammer et al., 2014), shed light on warning signs which are not easily observable to staff, and provide insight into the service users view and understanding of their risk (Ray & Simpson, 2019). Collaboration may lead service users to take increased accountability for their own recovery (Kroner, 2012), or provide access to internal mental states to support risk estimates and prediction (Vazire & Mehl, 2008). Collaboration can further service users' understandings of why certain interventions are necessary and support them to feel empowered (Kumar & Simpson, 2005). This in turn can help to enhance therapeutic relationships and reduce risk (Dixon, 2012; Hamann et al., 2003).

Collaborative risk assessment and management is seen as particularly challenging in FMH settings where care is provided under a coercive framework imposed upon service users (Ray & Simpson, 2019; Shepherd et al., 2016; Söderberg et al., 2020; Van Den Brink et al., 2015). The research indicates that service user participation in violence risk assessment and management is not always sought (Dixon, 2012; Eidhammer et al., 2014; Gough et al., 2015; Nyman et al., 2020; Schroder et al., 2016). This goes against the core principles of the recovery approach, and places the concept of risk assessment and management in the domain of the professional. Failing to collaborate with service users risks the omission of important information (Eidhammer et al., 2014), can disempower service users and limit their sense of agency and responsibility (Markham, 2020), and may foster a sense of mistrust toward health professionals (Shingler et al., 2020). These drawbacks may ultimately serve to increase risk rather than reduce it (Markham, 2020). It is thus pertinent that service users are involved in their own risk assessments and management plans, rather than seen as passive recipients of the process.

The factors inhibiting effective collaboration are complex and several suggestions have been made to explain the challenges. For one, staff may be conflicted with the apparent contradiction of providing care while protecting

the public. They may want to avoid challenging conversations which they feel may negatively impact the therapeutic relationship (Gough et al., 2015; Levin, 2019). Arguably, therapeutic relationships, which are essential for true partnership working, can be more difficult to achieve in FMH settings. The process of building trust and rapport can be challenging due to the coercive nature of FMH. The often uncaring and cruel early life experiences of individuals in these settings can result in disrupted attachment styles, which may make the development of secure adult relationships more difficult (Mann et al., 2014). Professionals fearing for their own safety has been cited as another possible barrier to the development of relationships (Langan & Lindow, 2004), as well as differing priorities between service users and staff, and varying levels of insight into offending behaviors (Markham, 2020).

Collaboration in FMH settings is clearly a complex matter. Based on the available literature, it would appear that the extent to which this is occurring may be suboptimal (Dixon, 2012; Eidhammer et al., 2014; Levin, 2019; Nyman et al., 2020; Schroder et al., 2016). Research indicates that staff are open to including service users in the process. However, there seems to be a gap between staff beliefs and practice as collaboration does not appear to translate into practice. Nonetheless, in line with recommendations, there is a duty to support collaboration and a balancing act is required (Söderberg et al., 2020). If violence risk assessment and management is going to be effective, it needs to be collaborative and meaningful, where service users can become assessors and managers of their own risk.

Risk assessment and management from service users' perspectives

Both Sullivan (2005) and Coffey (2006) highlighted the scarcity of literature exploring service user views in FMH. There is a particular dearth of research about how FMH service users view the risk assessment and management process (Markham, 2020). This is surprising given that risk assessment and management is central to the lives of FMH service users, as these practices dictate how they progress through the system, with release or restrictions being dependent on favorable outcomes.

The limited literature paints a stark picture. Service users are often unaware of the content of their risk assessments and are frequently not included in the process in a meaningful way. Dixon (2012) investigated FMH service users' experiences of risk assessment and management in a community setting. He found that service users were generally aware of their risks being assessed but reported low levels of involvement in the process. They were generally informed of their assessment rather than having contributed to it. Service users were often unaware of the content of the assessment, with one third of Dixon's sample reporting never having seen their risk assessment. The majority of service users felt that the risk assessment and management process had

not supported them to reduce or manage risks in any way. More positively, the small minority of participants in Dixon's (2012) study who had been included in the process showed a greater level of engagement. These participants felt comfortable to discuss risks and were clear on what they would do in the event of a setback.

Dixon (2012) reported that participants who had viewed their risk assessments often disagreed with the content. However, they felt they had limited influence to disagree and as such went along with it in order to have a chance of progressing. This process of acquiescence with professional views is consistent with the findings of an observational study by Reynolds et al. (2014) in a sample from medium and low secure FMH settings. Reynolds et al.'s (2014) participants sought to manage and reduce their risk status through compliance with professional views. Shingler et al. (2020) reported similar findings in a prison setting, where service users attempted to reduce their risk status by engaging in compliant behaviors. They believed that disagreeing or expressing dissatisfaction could be seen as lacking insight which could be interpreted as an increased risk indicator and adversely affect discharge or release decisions.

Shingler et al.'s (2020) participants referred to experiences of risk assessment as "*daunting*," "*horrible*," "*terrible*," "*stressful*" and "*scary*" (p. 580). Many participants lacked an understanding of the basic concept or purpose of risk assessment. Participants spoke about how a lack of control contributed to feelings of powerlessness as professionals had the final say over the content. Similarly, prisoners in Attrill and Liell (2007) study reported experiencing risk assessments as stressful. They wanted consideration given to their strengths and progress rather than a focus on weaknesses and risk factors. Participants in this study described a feeling of entrapment based on their past offenses. They wanted to understand the risk assessment process and be involved in it. Both prison studies presented risk assessment as a largely negative experience for prisoners. The process was seen as unfair due to focus on history and lack of attention to progress, strengths and protective factors.

The current study

Sullivan (2005) and Coffey (2006) first highlighted the lack of service user views in FMH research. Although limited progress has been made in recent years, significant gaps in our understanding of FMH service user views remain. This is particularly notable in the case of violence risk assessment and management, which has come to dominate how FMH services are managed. Findings from limited studies in FMH settings have illustrated that service users generally see risk assessment and management as a negative experience, are often unaware of the content of their risk assessments, and are not involved in a meaningful way. Participants also described a process of compliance with professional views (Dixon, 2012; Reynolds et al., 2014).

As has been demonstrated, research regarding experiences of service users in FMH settings is largely absent from the literature. While research from prison settings (Attrill & Liell, 2007; Shingler et al., 2020) is useful to draw parallels with FMH settings, it is important to note that the nature of a FMH setting is pointedly different to that of a prison in many ways, for example, in terms of physical environment and emphasis on mental healthcare. It is thus possible that the experiences of risk assessment and management may differ between these settings and as such prison research should be interpreted cautiously when drawing comparisons.

Furthering our understanding of how FMH service users experience the violence risk assessment and management process is crucial to enable practitioners to maximize engagement and allow service users to be meaningfully included. Further exploration of this topic will address this gap and give a voice to FMH service users in these settings. This will add to the limited literature base, guide future research, and may lead to improvements in violence risk assessment and management. This will have the potential to improve quality of care and safeguard the individual and the public.

Methods

Design

Given this study seeks to explore the risk assessment and management experiences of FMH service users, in which only limited literature exists, a qualitative approach was deemed most suited to address the subject matter. This research utilized an Interpretative Phenomenological Analysis (IPA) approach, which has been successfully used in studies investigating the experiences of forensic populations (e.g., Ferrito et al., 2012; Stuart et al., 2017). IPA offers an exploratory approach to understand lived experiences, informed by the philosophical principles of phenomenology and hermeneutics (Smith et al., 2009). Given the topic itself is novel and requires elucidation, IPA was deemed an appropriate methodology.

Sample

Participants were service users from two low secure mental health inpatient wards in Scotland. The wards serve persons with complex mental health needs requiring care, treatment, and rehabilitation in a safe and secure environment. Common diagnoses of individuals on the units were paranoid schizophrenia and personality disorders. Service users who had a completed violence risk assessment on file were eligible for the study. The risk assessment tool used most consistently on the units was the HCR-20 v3 along with more specific risk assessment tools when deemed necessary. Identification of eligible

participants was facilitated by the ward staff who liaised with the individual's responsible medical officer (RMO) to confirm that the person had capacity to consent to take part in the study. If the individual was deemed to have capacity to consent, the ward staff provided the potential participant with a copy of the participant information sheet (PIS) and provided some context about the study. Service users who indicated interest were offered a meeting with the researcher where the PIS was again reviewed. As outlined in the PIS, potential participants were advised that their participation was voluntary, and that they had the right to withdraw from the study at any time. If the individual wished to participate, a written consent form was signed by the participant and the researcher.

Although there is no definitive sample size for IPA methodology, Smith et al. (2009) suggested that a sample of between four and ten is appropriate for a professional doctorate level research project. The idea behind this number is to allow a deeper exploration of a smaller dataset, rather than a more superficial analysis of a larger dataset. Smith et al. (2009) suggest that, rather than sample size, the most important factors to consider are the commitment to the case study level of analysis, the richness of the data, and the constraints within which the researcher is working.

Seven FMH service users were interviewed in this study. Participants were recruited from a small population in Scotland, and as such demographic details have been kept to a minimum to ensure anonymity. Participants were all male aged between 20 and 70 years, with the modal age group being 35–50. All service users who took part were bound to varying restriction orders at the time of interview. The average duration of secure inpatient admission was 17 years.

Data collection

Semi-structured interviews are seen as the optimal method of data collection for IPA (Willig & Rogers, 2010). As such, data was collected via this method to allow participants to explore feelings, thoughts, opinions, experiences of risk assessment and management, and the meanings attributed to these. As per Smith et al.'s (2009) suggestion for an IPA study, a list of 6–10 interview questions was prepared, along with prompts and probes. This was intended to be suggestive, not definitive. Broad and open-ended questions were used to allow the interviewer to get as close as possible to the person's view of the topic. The interview covered questions such as what the person knew about risk assessment and management, and how they would describe their own experiences of the process. Questions were modified according to responses, allowing the researcher to prompt and probe where necessary (Smith et al., 2009). The researcher placed emphasis on the importance of establishing rapport with the individual, and the interviewer was free to probe and follow

participant's areas of interest. No interview lasted longer than 45 minutes. Interviews were audio-recorded using an encrypted password protected recording device. All interviews were anonymized during the transcription process and each participant was allocated a pseudonym.

Analysis

Dedoose (software which supports the analysis of qualitative research, available at <https://www.dedoose.com/>) was used to facilitate the IPA analysis. Although it is acknowledged that there is no set way to conduct analysis in IPA research (Smith et al., 2009), the analysis loosely followed the steps suggested by Smith et al. (2009) which involved: 1) reading and re-reading the transcripts; 2) initial noting of significant content, language and concepts to attempt to make sense of the interviewee making sense of their experience; 3) development of emerging themes at the case level; 4) searching for connections across themes; 5) moving to the next case and following steps 1–4; and 6) looking for patterns across datasets.

Ethical considerations

The study was approved by the University of Edinburgh Ethics Committee and registered with the Quality Control team at the relevant NHS board. An encrypted recording device was used to record all interviews, which only the first author had access to. The researcher anonymized (service user identifiable data removed) all interviews during transcription. The recordings were deleted following transcription. Ward staff provided a handover to the researcher prior to each interview regarding potential safety issues, and the researcher reciprocated this to ward staff following each interview. Contingency plans were in place in the event a participant became distressed, however, these were not needed to be acted upon.

Given the restricted nature of FMH settings, additional considerations were given to the validity of informed consent, as it is possible service users may have felt that accepting or declining to take part could affect their treatment or restrictions. To minimize this ethical concern, the researcher ensured that potential participants were informed on multiple occasions that accepting or declining had no bearing on their treatment. Similarly, the researcher reiterated to ward staff that participation was entirely voluntary, and no pressure should be put on anyone to take part in the research.

Due to the nature of the interview, the researcher acknowledged that it was possible that a participant may disclose information which may be deemed to indicate a risk to the person, or to the public. As such, the researcher ensured that participants were informed of the constraints of confidentiality prior to the interview.

Quality in qualitative research

Quality control is of utmost importance to high-quality qualitative research (Smith et al., 2009). As far as possible, this study adhered to the suggestions outlined by Smith (2011) and Yardley (2000) for ensuring quality in qualitative research. As per Smith's (2011) guidance, this included having a clear focus, demonstrating sufficient extracts, providing detail regarding the level of prevalence needed to constitute a theme, going beyond descriptions and providing an interpretative account of each theme, and accounting for convergence and divergences across transcripts.

Yardley's (2000) criteria offer a variety of ways to establish quality, centering on the importance of sensitivity to context, commitment and rigor, coherence and transparency, and impact and importance. Sensitivity to context was demonstrated via the researcher reviewing the existing literature and considering how the identified themes linked to what was already known. The researcher also paid attention to the context in which the research occurred, in particular the relationship with the participants, and the potential power imbalance. The researcher attempted to be attuned to this. For example, a mock interview was conducted to get feedback on tone prior to conducting interviews. As the researcher was working clinically in the service at the time the study was conducted, a point was made to ensure only participants not clinically involved with the researcher were invited to the study. An adequate sample size was achieved (Smith et al., 2009) to allow for an in-depth detailed analysis, adding to the commitment and rigor of the study. Consideration was given to potential biases in the study when interpreting the data, such as sampling bias (e.g., that individuals with excessively positive or negative experiences may be more likely to take part). A clear audit of all stages of the process has been maintained by the researcher to ensure coherence and transparency (e.g., transcripts, notes on development of codes). These will not be published but will be available to view on request. In addition to this, a selection of the coding was shared with the third author and all final themes were discussed to ensure they were substantiated by the data.

Results

Interpretative phenomenological analysis identified four superordinate themes, with between two and three subordinate themes each. These are displayed in Table 1, along with theme prevalence and a breakdown of the participants represented in each theme. A theme was defined as recurring if it was present across three or more cases in the sample. As per the guidance of Smith (2011) extracts from at least half the participants are provided as evidence for each theme.

Who is this for?

All participants spoke of their experiences of collaborating with staff and it was clear there was a wide spectrum of perceived levels of involvement. There was a general sense from the majority of accounts as risk assessment and management being done “to” participants, rather than “with” them. Risk assessment was often perceived as a tool to serve professionals.

Whose risk assessment?

Participants provided diverging accounts of their experiences of collaborating with professionals on their risk assessment and management plans, with variation regarding the extent to which service users perceived that they had worked in partnership with staff. There was a general sense from the majority that risk assessment and management was something done by staff rather than something they had actively participated in.

Three of the service users described largely positive experiences of the process, though levels of collaboration differed even amongst these three accounts. Joe was the only individual in the sample who was able to provide a coherent overview of the process of collaborating with staff. His account differed from the others in that he was able to clearly outline his role in the process. Joe indicated that collaborating with the team had been a core element of his positive outcome.

Joe: the staff as a team, they come together as a team, the doctors are there, the staff nurses are there, the psychiatrist is there, and the students are there. So, what they're doing is they're educating the students and they're educating you educating themselves and giving me their experience of what they think is wrong with you and what could be better for you.

Table 1. Superordinate and subordinate themes.

Superordinate / Subordinate Theme	Participant							Prevalence
	Greg	Nick	Joe	Don	Brian	Mark	Matt	
3.1 Who is this for?								
3.1.1 Whose risk assessment?	✓	✓	✓	✓	✓	✓	✓	100%
3.1.2 Do I want to know?	✓	✓	✓	✓	✓	✓	✓	100%
3.2 Power								
3.2.1 Mistrust	✓	✓	✓	✓	✓	✓	✓	100%
3.2.2 Staff hold the power	✓	✓		✓	✓		✓	71%
3.2.3 Playing along	✓	✓	✓	✓	✓	✓		86%
3.3 Misunderstood								
3.3.1 I Am I a threat?	✓	✓	✓	✓	✓	✓	✓	100%
3.3.2 They don't see me	✓	✓			✓		✓	57%
3.4 Moving forward								
3.4.1 Judged by my past	✓	✓					✓	43%
3.4.2 Taking responsibility for myself	✓	✓	✓		✓		✓	71%
3.4.3 Thinking about the future	✓	✓	✓	✓	✓		✓	86%

It appeared that Joe saw his risk assessment and management plan as something valuable which served to move him forwards. He saw collaborating with staff as a vehicle to achieving his goals. He described how staff told him what *“they think,”* implying that he perceived staff to be giving him suggestions or offering their understanding, rather than informing or telling him. Joe made reference three times during the interview to himself and the staff all having signed the physical risk assessment document, which seemed to have been particularly meaningful for him, perhaps instilling an increased sense of agency over his role in the plan.

Greg and Brian also provided positive accounts, though the exact details of their involvement were less clear. Greg and Brian were both close to discharge which may have impacted their outlooks. There was the sense of risk assessment and management being done *“to”* them, rather than *“with”* them. Greg described risk assessment and management as something which served to protect him, *“it’s there for your support, it’s there for your, eh, to keep you safe.”* Greg advised he was involved in his risk assessment interview and recalled being asked questions about hypothetical scenarios. However, when referring to ongoing risk decisions, it was evident that Greg saw this as something decided by staff. His use of the word *“you”* rather than *“I”* in the extract below implies he saw himself on the receiving end of the communication rather than as an active participant in decisions.

Greg: Well, you just sit round a table, they get an update about the last month of how you have been in the ward, and how you’ve been reacting to things, they’ll maybe give you some time out, more time out, or pull it back or they’ll talk to you about different things.

Brian’s views on collaboration diverged across his transcript. Initially he expressed frustration about only being involved in the first stages of his risk assessment, *“well you are included in it when they were asking questions, but you don’t find out nothing after that.”* Brian felt that staff worked with him until they got what they needed. It was evident he viewed risk assessment and management as something done by the staff team, *“whatever they have done, it has worked for me, so I’m not too bothered with the risk assessment and all that, but I would have been before, if I wasn’t getting out.”* Brian seemed unconcerned about the differing perspectives which were evident in his transcript between himself and staff, on the basis that professionals had acted in his best interests and as the outcome had benefitted him. However, he later described how collaborating with staff had supported him to become well and move forward with his life, *“if Dr [name] hadn’t listened to what medicine works for me and compromised with me I wouldn’t have got well.”* His use of the word *“compromise”* implies he was not just on the receiving end of this decision, and that he felt it was a true shared decision-making process.

The other four service users accounts were significantly different, with Matt, Mark and Don all either being unaware or unsure whether a violence risk assessment even existed. Don had no knowledge that he would be subject to a violence risk assessment despite being in secure care for over 40 years.

Interviewer: How would you describe your own experience of risk assessment?

Don: Me?

Interviewer: Yeah.

Don: Well, I've never got involved in that on the ward, no. I don't think I'm a risk assessment on the ward.

Don's surprise at the concept of a risk assessment being associated with him was evident in his questioning tone when the question was posed. His use of the phrase "*I don't think I'm a risk assessment*" suggests he saw risk assessment as a personal attribute or characteristic. Both Mark and Matt were aware of the general concept of risk assessment and management but were unsure if they had one. Both appeared unaware that they had been missing out on this process, and expressed frustration about not having been included, "*I don't think that's right*" (Mark). In contrast, Nick was aware of his risk assessment and had been asked to be involved but had made the decision not to contribute, "*I don't see any reason to work with them because their minds are made up.*" Nick viewed collaborating with staff as something that could add little value to his situation and seemed to view the risk assessment as a tool staff used to appease the public, "*I just think a lot of it is unreasonable, a lot of it is for show, there is nothing seriously being done.*"

Do I want to know?

The service users in the study described the importance of transparency in the assessment and management of risk. However, all participants, with the exception of Joe, advised they had never seen a copy of their risk assessments and were unsure as to the content. Risk assessment was perceived as tool to serve professionals, not the participants. Not knowing often left participants feeling insecure and suspicious.

Brian: It's upsetting, because you don't know what the doctor has wrote about you. You don't know. It's like somebody whispering about you behind your back.

Mark advised that he wanted to see what was written about him, as did Brian and Matt, however none of them described having taken any action to access their risk assessments.

Mark: ... cause I should know what they are saying about me. If what I'm saying is not confidential then what is being said about me shouldn't be confidential

Interviewer: How would you like it to be?

Mark: I'd like them to show me what they are writing about me.

Mark's view of the assessment being confidential or out of his reach may have been constructed as a façade to explain why he didn't know anything about it. He pushed the responsibility onto staff to show it to him and showed a lack of interest in taking any action to see it himself. He appeared to lack insight into what knowing could mean for him, or how he might be able to use this information for his benefit. Despite initially saying he wanted to see it, Brian later expressed hesitation about whether he would truly want to know the content.

Brian: It's like your notes, you never get to see your notes. But then again if I wanted to see my notes I'd be looking at 20 years of notes. I mean how am I meant to get through that! That's like (makes hand motion) that high off the ground! (laughs)

Brian used humor about the practicalities of gaining access as a deflection of a potential deeper fear of the discomfort of being confronted with a reminder of how long he has been in hospital, or perhaps the potential unease of seeing the content of his assessment. Greg and Nick had also not seen their risk assessments, but in contrast, were both clear from the outset that they would prefer not to know.

Nick: Well, it's stressful, I think I never look at the notes or anything that is sent to me, because you know I can't believe they're writing all these things in that context, you know it's frightening, I just stay away, I just don't wanna deal with that.

Nick appeared overwhelmed by the idea of knowing. Avoiding the content likely served as a means of protecting himself from the unpleasant emotions reading it may bring. Nick justified not seeing the assessment as in his view it would need changing and was not reflective of his situation, "*I know it's just general rubbish.*" Greg advised he was "*not bothered*" to see it as he wanted to focus on his future.

Greg: I wouldn't even want to see it because I know that I'm alright, and I just, try and keep focused and not keep looking back at bad times, just look forward getting my life and my house.

It was evident that the majority of the participants saw risk assessment and management as a tool to support staff. They viewed it as something which would move them backwards, rather than a tool to support their recovery.

Power

Issues relating to power, or indeed, disempowerment, were evident across the transcripts.

Mistrust

Feelings of disempowerment underpinned by feeling mistrusted by staff members were pervasive across the sample. Service users felt their voices were not important in decisions about their care.

Matt: I've said to the doctor that my intentions are to lower my alcohol intake and drug use to a minimum, so these kinds of things are not likely to happen, and for it not to affect my everyday life, and the week that I've got scheduled, like doing activities and maybe doing a course, or attending appointments or whatever. But he's just not listening to me, he's not giving me the chance to go out there and do it.

Matt expressed frustration about how staff were not able to see things from his point of view. He felt he would never be trusted to move forward with his life.

Matt: it's just other people's opinions about you. Sometimes they are not very nice. It is sometimes hard to accept.

Matt didn't believe that his risk assessment was a fair reflection of the truth. His use of the word "*opinions*" implies that he felt the risk assessment was not based on fact or knowledge. He acknowledged that this made it hard for him to accept. Nonetheless, the power imbalances evident in secure care left him feeling helpless to do anything about it. Greg echoed similar concerns about not feeling trusted by staff.

Greg: I'm saying to them that I want to go out of hospital, "I'm ready, I'm okay," well I am ready, I'm okay to go out of hospital, but, eh, just when they keep saying that, and your focused, and you think you're not getting listened to it turns into, oh, you're the bad people, and it just gets into a mess and I think that's where sometimes everything gets mixed up in here.

It was apparent that service users felt that their views were not believed or important and had no bearing on decisions. There were clear tensions between the views of staff and service users. Feeling mistrusted appeared to foster a sense of reciprocal mistrust toward staff, underpinned by the lack of therapeutic relationships noted by some participants.

Nick: they don't give a toss, it's just a job to them, some of them are like whatever, some of them try more than others. I personally just want as much distance as I can between them.

Hostile and suspicious attitudes toward staff were evident in the transcripts.

Don: I know they have got it in for me you know. I know they have got it in for me.

Consistent use of the word “*they*” and “*them*” amongst the transcripts highlighted the divide felt by participants between themselves and staff. There was a strong sense among the majority of accounts that staff are not to be trusted and are there to restrict rather than to support.

Staff hold the power

This theme was evident across the majority of transcripts. Service users expressed frustration about the dominance of the staff view mixed with feelings of helplessness to do anything about it. Participants felt that they had limited power to influence decisions as their points of view would not be heard or valued.

Nick: I keep asking for things, because you know the nurses can be difficult, so I think like you know, I have to ask for a bar of soap or shampoo, and you know toiletries, and I have to ask to get in and out and stuff like that, I think there’s just no independence, you are totally dependent when you’re in hospital. They’re feeding me and you can’t do that yourself and you can’t take control for yourself you have to ask them to have a shower in the morning you can’t control that yourself.

Having to ask permission to meet his basic needs resulted in Nick feeling powerless and lacking agency. Nick described distorted relationships between service users and staff due to this power imbalance.

Nick: It wouldn’t be such a big deal if they didn’t make such a hassle out of it like I asked the nurses “can I get out,” “no,” and then you are stuck there, and you’re like, well I don’t know what to say to that, and then they’ll say “alright” and that’s really difficult, just one of the most common demeaning things they do.

It was clear this perceived expression of power by staff had a negative impact on Nick’s emotional world, leading him to question his own self-worth and dignity.

Interviewer: what does that feel like?

Nick: it feels really bad because you know, you’re not doing anything, this is the only thing that I actually have to do, and it’s gone bad, it makes you feel smaller because they are doing that, how can they treat us like that.

Nick equated the power staff hold to that of a god, “*they’re almost like your god and that, and they know how much it hurts you if their asses to you, and they still do it.*” Nick implied that staff are aware how their actions affect service

users, but choose to proceed, hinting that he felt staff consciously abuse their power and enjoy it. This led to him feeling disempowered and dehumanized. Perceived differing views between staff and service users were evident in many of the accounts and there were clear tensions between who knows best, staff or service user. Participants conveyed a sense of powerlessness to do anything about these differences due to the perceived weight of the staff view over risk decisions.

Don: What will you do (laughs).

It was clear many of the sample felt that there was no point voicing their opinions as they would have no impact on decisions.

Interviewer: Do you think that is written in your risk assessment?

Brian: It probably is.

Interviewer: How does that make you feel?

Brian: Well, there is nothing that can be done about it.

The desire for things to be different, compounded by feelings of powerlessness and acceptance of an inability to do anything about it, speaks to the disempowerment experienced by the participants.

Playing along

The power imbalance and perceived limited power to disagree with professional views, as well as mistrust toward staff evident in the previous themes often led to service users regulating their communication and behavior in order to be viewed as compliant. Service users perceived that disagreeing with staff would be viewed through a lens of risk and could be seen as lacking insight which could hinder progression through the system.

Mark: you can't speak your mind because you know if you say some stuff then they take it serious.

Engaging in compliant behavior and "*keeping out of trouble*" (Greg) seemed like the path of least resistance. Service users described behaving in ways that would be seen as low risk, "*you follow the rules and stick to the rules*" (Joe). Joe described how recreational drugs were regularly available but he was aware that this could result in him being found out via the routine drug testing system. His insight into how his risk was assessed meant that he regulated his behaviors to ensure he continued to progress toward discharge. Brian described how he regulated what he reported to his psychiatrist, as he knew it affected his treatment.

Brian: If you've got anything like that to speak about, about god or the devil, you speak to the priest about it.

Interviewer: Why's that?

Brian: Because I don't think psychiatrists understand it, or if they do, they end up putting you on medication.

Brian believed that his religious beliefs should be discussed with the priest, as the psychiatrist was likely to see these as delusional symptoms. He thought that being open with his psychiatrist would mean being put on a certain medication which would “*take the edge off*” and result in him staying in secure care for longer. Thus, regulating what he reported was a means of playing the game to meet his goal of being discharged. Interestingly, Brian also spoke of an example where he regulated his communication in order to access support.

Brian: . . . well I said to them to get me in hospital because I was so violently ill, and the doctor wouldn't listen to me, I said I was going to set my house on fire, and jump out the window, and I wasn't really. I was just needing help.

The participants showed an awareness that regulating what they communicated and how they behaved yielded desirable outcomes. Playing along did not imply acceptance of staff views. Service users were aware of what they needed to say or do and had evidently reflected on this. In a way, participants regulating their communication and behaviors can be seen as a means of taking back power from staff and exerting some element of control. By being compliant and not disagreeing with staff, service users were engaged in the process, but through passivity and compliance rather than active engagement.

Misunderstood

Participants described feeling misunderstood about the prospect that they could be seen as violent and felt that staff viewed them through an unduly negative lens.

Am I a threat?

All participants in the sample, with the exception of Mark, struggled with the idea that they could be perceived by others to pose a risk of violence. Participants gave varying accounts and reasons for being in secure care, which likely served as a means of protecting their sense of selves. Mark was the only service user in the sample to identify with being violent. He expressed frustration about being classified as a mental health service user rather than a violent offender.

Mark: I feel like I shouldn't be in hospital, I should be in prison. There's nothing wrong with my mental health. I'm a violent offender, I'm not attacking people because I'm hearing voices or anything like that, I'm attacking them cause I want to attack them, and I enjoy it.

Mark's comments highlighted the extent to which he rejected his association with mental health. Mark agreed he posed a risk of violence to others but didn't feel that this was a sufficient reason to be in secure care. Mark saw being labeled as mentally ill as worse than being seen as violent and was proud of his violent identity.

Mark: I don't feel that this is anything to do with my mental health so I shouldn't be in here I should be out in the community. What happens happens.

In contrast, the rest of the participants did not identify as violent and struggled with the idea that they may be seen in this way. Brian spoke about how risk assessment and management is different in FMH settings as "*it's a lot more serious because you are seen as a violent patient*" and "*you are seen as a threat basically.*"

Interviewer: What does it feel like to know that you are risk managed? What's that like?

Brian: It doesn't feel very nice, especially when you know in your heart that you are a good person without a bad bone in your body, and if you ever were to get in trouble like a fight or something you would just be protecting yourself you know? And self-defense. But other than that, I'm not a threat.

Brian expressed his inner turmoil about the stigma associated with being a forensic service user. It was evident he placed significant importance on how staff viewed him, which made him question his own appraisal of himself.

Brian: It makes you feel like, when you are just looking for help, it makes you feel like you are getting picked on by the forensic, because you know inside you're not a threat.

Later in the interview, Brian, who was a few weeks away from discharge, spoke with pride about how he now gets marked by staff as "*green*" and how he is getting "*normal*" psychiatry in the community. In his mind, this meant that staff no longer viewed him as a threat. It was clear that Brian was very proud to have shaken the stigma of the "*violent*" identity.

Despite Don's violent past, or what he referred to as "*that day in 2005, I lost control,*" and "*my past misdemeanors are not very good,*" he did not associate himself with violence in any way. Don acknowledged that if someone is violent, they would be risk assessed and managed, but did not relate this to himself and seemed to struggle with the idea that this could be a possibility. Don related risk assessment and management to current violence and/or mental state, "*I know other people in the wards are being violent or whatever but I'm not like that.*" He often made reference to his age and length of time which had passed since the offense, and that he

had never been violent while on the ward. Various other explanations were given by service users to explain being in secure care. Joe attributed being in secure care “*because the medication we take*” rather than due to the risk he is deemed to pose. Matt attributed any risk of violence to alcohol which made him do something “*out of character.*” It may be that attributing violence to external factors and not succumbing to the violent role served as a way for participants to protect their appraisals of themselves.

They don't see me

Participants felt that risk assessments were “*unduly negative*” (Nick), with too much emphasis on the “*bad stuff*” (Greg). Service users spoke about how they felt they were expected to fail, leaving them feeling like there was no point trying, Nick: they're just like you know, do this and that, in their mind they're like, we'll see you later when you get drunk we'll have to deal with that pull you back or whatever.

Greg's experience was similar.

Greg: when I say to them, “look I'll not do it again,” “well what makes it different?,” “well I'm in a better place now, I've learned from my mistakes,” and still they're saying right well you're coming up with strategies, before you break down and you go away again.

Greg spoke about pleading with staff that he won't do it again, but often felt that his position was not validated, and that staff were discrediting him.

Greg: I just feel alone thinking about it, the feeling you get, it's like overwhelming thoughts of failure kinda thing, you feel like you'll fail before you even start.

Several participants spoke of their perception of how progress goes unnoticed, with only the negatives being given attention. Participants were frustrated that their progress gets overlooked when risk decisions were made.

Matt: I'm still viewed as though I'm still capable of doing the same thing again when I've been rehabilitated in the system over the period that I spent in [forensic facility]. I done a lot of group therapy and group work, that's why I was in there for so long, as I was on the list to do this group work and I wasn't able to leave there until I did it, and I did it, and I did it successfully. It was really beneficial for me. I feel as if all that is overlooked when assessing whether or not I am a serious risk or not. It's been overlooked.

Greg spoke about the importance of staff highlighting protective factors, or areas where service users are making progress. He indicated that staff giving positive feedback was the exception rather than the norm. Greg sought positive feedback or acknowledgment of his progress and it was clear he, and others, didn't feel sufficiently validated by staff.

Greg: ... if you are risk assessing people and talking about risk assessing people you've got to ensure them that the good they are doing as well.

Evidently, staff responses had a big impact on how participants felt about themselves. This makes sense in the context of secure care, considering most of the participants' time and engagements are with members of staff. There are limited other avenues participants can use for support or to build a more positive image of themselves, but plenty of time to spend reflecting on negative experiences.

Moving forward

Participants provided varying accounts of their abilities to move forward, and the level of control they felt they had over their futures.

Judged by my past

Particularly intense negative emotions were evident in the narratives of this theme. Three participants described feelings of entrapment, and how living in the shadow of the past limited the extent to which they could move forward. This subgroup felt that staff placed too much emphasis on history or what they had done.

Matt: it doesn't feel very nice at all, it feels like I'm being judged. It feels like they are never going to get over what happened and it's going to be with me for the rest of my life. It's never going to, they're always going to look at that first when they're judging my character, you know?

Matt compared himself to the general public who drink alcohol but do not have to experience the same consequences, "... *everyday people have drug and alcohol problems in the past and they have been able to control it, you know what I mean?*" Matt compared himself to another service user who got released but reflected that this would never happen for him due to the nature of his offense. Seeing others leaving served as a constant reminder of his inability to leave due to his past.

Matt: it's frustrating cause I see people going out in the community from here ... and I believe that I should be given the same opportunity, but I don't think I have been given the opportunity and I think it's down to my risk.

Matt referred to "others" a number of times in his transcript (e.g., "*people*") and consistently referred to "*they*." This distance in his language between how he saw himself being treated differently is notable. He justified that this was due to the severity of his crime. On one hand he appeared to understand that his offense was more severe than others' and was able to recognize why the

consequences were more severe for him. But on the other hand, he seemed to perceive that being kept “*locked up*” was unjust, because everyone drinks, so questioned why he is held in secure care. He showed an interest in being like the “others” but it was perhaps his lack of understanding of the risk assessment process which prevented him from being able to be judged a lower risk. Unlike the participants in the previous theme, “playing the game,” Matt potentially lacked insight into how he could influence his risk assessment.

Other participants held similar concerns to Matt. Nick expressed frustration about how “*the patient isn’t always focused on, it’s what the patients done*” and how “*once you do something wrong you are on the backfoot.*” Greg reflected on how the past will always be something that follows him, no matter how hard he tries or what he achieves while in secure care.

Greg: It’s been tough, sometimes really tough, cause, like, they always bring up the past like when I was younger around 16, drinking all the time, getting in jail all the time, taking drugs, I was always getting into trouble, so, eh, I just feel like when you’re trying, when you come into hospital you get better mentally and to keep you there, but they keep bringing up the past, what you’ve done.

Participants were frustrated and wanted an opportunity to prove themselves but felt they would never get this chance due to the weight placed on past offending. There were significant tensions about how service users can be expected to progress in their recovery journeys without a chance to prove themselves.

Greg: well, you can’t keep bringing the past up that was years ago that was when I was young so I need that chance to prove that I can do it.

The use of the term “*judged*” and “*judgmental*” across the transcripts in this theme implies that service users felt professionals were overly critical of their characters, suggesting that they felt their risk assessments were not valid or justified. It may be that staff see discussions about events of the past as important in terms of the learning, insight and responsibility needed to move forward, whereas service users see this as something that will move them backwards.

Taking responsibility for myself

Five participants spoke about an enhanced sense of responsibility which appeared to have come about through the risk assessment process. For some, this sense of responsibility supported moving forward in their recovery journeys, whereas others still felt stuck.

For Greg, Brian, and Joe, taking responsibility for themselves helped them to move forward. Greg discussed the positive feelings that are evoked in him when he is “*proving that you can do it*” and Brian spoke with pride about how he is “*getting left with my tablets*” when he gets out. Joe described how

reading his risk assessment gave him insight into how his negative behaviors were impacting his life. Seeing the content of his assessment served as a wakeup call for Joe, “. . . *it was a bit funny at first but then I looked at it and said no that can't be me and then I realized it was me.*” Reading the risk assessment helped Joe become more aware and understand what he was doing “*wrong.*” Joe expressed remorse for his actions and described taking increased responsibility by engaging in illness education to ultimately reduce his risk. Joe advised that he is now able to recognize when he becomes unwell and seek support from staff. He referred to himself as a doctor in a joking manner, indicating he sees his level of knowledge about his own illness as on par with the staff.

Nick and Matt both gave descriptions of taking responsibility, though in their cases it did not seem to change anything for them on a day to day basis or support them to move forward. Although Matt felt frustrated being judged by staff, he acknowledged that the offense work he completed supported him to learn the difference between right and wrong.

Matt: I understand the things that I have to avoid, and the things that I'm not supposed to do. I believe I will never come close to committing an offense like that again, cause at the time I didn't know the difference between right and wrong.

Matt's frustrations noted in earlier themes highlight a potential lack of understanding that rehabilitation can involve multiple components. Although he completed one facet, he continued to engage in other risky behaviors and rejected the team's view that drug misuse was likely to lead to a future mental health relapse. He potentially lacked the understanding that one facet of his rehabilitation alone would likely be insufficient to be considered for discharge.

Nick spoke of decisions he has made to keep himself and those around him safe.

Nick: I made the decision to be here unless there's anything better for me. And I think I just feel that I'm being responsible for myself because I think if I was out there and I went wrong then obviously something is going to happen.

Nick's decision to remain in secure care showed a sense of insight and responsibility in that he knew he may be likely to reoffend if he were to be released. Remaining in care served as a way to protect himself, and others, from harm. However, as described in the theme “*Who is this for?*,” his decision not to take part in his risk assessment also shows a potential lack of understanding of the purpose of risk assessment and management and is likely serving to perpetuate his fears about living independently one day.

Thinking about the future

Six of the participants made reference to the future when reflecting on the risk assessment and management process. Whilst three of the sample described a lack of agency over their futures, three participants felt they had more influence. For Greg, Joe and Brian, being able to imagine a future appeared meaningful, keeping alive the reality of life beyond the confines of the ward. Greg acknowledged the good and bad of being on the ward, but overall was proud of himself and the steps he had taken to progress toward release. Greg talked about how he continues to look forwards and focus on what he does have, such as *“getting my life and my house.”* Joe and Brian also spoke positively of their futures. Joe described how he focuses on the positives to move forward, such as activities in the ward. Brian spoke about how he concentrates on his resources, such as support from his priest. He said he can now *“forget about it”* and talked about how things will be when he is in the community, *“I will be behaving myself! Going to the gym, going swimming, going to the chapel. I want to have a wife; I am about that age to start my own family.”* The idea of a life outside the ward was clearly an important motivating factor for this subgroup. This was perhaps mediated by the fact that these were the three participants who had perceived that they had collaborated on some level in their risk assessments and the same individuals who were moving in the direction of discharge.

However, not everyone saw their futures through positive lenses, instead providing accounts of regret and hopelessness about the future. Matt expressed disappointment over what could have been and was not able to see any future that was meaningful for him, inside or outside of the ward, *“my life would have been totally different, it probably would have taken a hugely different direction, I probably would have had a family and stuff like that by now, it would have been a totally different life.”* Don spoke about how his life might have been different *“if I just talked to someone.”* In perhaps the most in-depth account, Nick expressed the despair and hopelessness he felt about the future, *“I can’t see beyond in here,”* and described how it would take ten years of working through the system just to be able to make the decision to go homeless. He was demoralized by the system.

Nick: . . . the only real way for me to do that would be to say to a doctor “I want a flat,” to do six months of psychology, perhaps do years of voluntary work, eventually move to that flat, stay in that flat for two to five years, could be longer, after a number of years have passed, do everything they tell me, go to appointments, talk to them, do all of that, and then when the restriction order has left or comes off, I’ll be under a community order or something like that for six months or a year or a year and a half I don’t know how that works, so do all that and then say, look now, I wanna focus on myself, I wanna go homeless, so that would be maybe 10 years down the line.

It was evident in the accounts of Nick, Matt and Don that they saw no future for themselves outside of the ward.

Discussion

This study explored the experiences of violence risk assessment and management, as described by service users in low secure FMH settings. Four superordinate themes were identified from the IPA analysis: *Who is this for?*, *Power*, *Misunderstood*, and *Moving forward*.

Despite the clear evidence of the value of a collaborative approach to risk assessment and management (Dixon, 2012; Eidhammer et al., 2014; Hamann et al., 2003; Kroner, 2012; Kumar & Simpson, 2005; Markham, 2020; Ray & Simpson, 2019; Vazire & Mehl, 2008), the results of this study indicate that the extent to which this occurs is limited. The majority of participants had not seen their risk assessment document, were insecure and suspicious about the content, and regarded risk assessments as being for the use of professionals rather than for their own recovery. These results are broadly consistent with the limited previous research (Dixon, 2012; Shingler et al., 2018, 2020). Similar to Dixon (2012) and Shingler et al. (2020) the few participants in this study who described positive experiences of collaborating with staff showed a greater level of engagement and sense of agency over their own progression. This also aligns with psychological research in other healthcare settings which reports on the benefits of service user involvement in care, such as increased satisfaction (Dwamena et al., 2012), and treatment adherence (Varming et al., 2015).

In spite of the emphasis on the importance of collaboration between service users and staff in the recovery literature (Slade, 2009), the majority of relationships were characterized by mistrust, hostility and suspicion. The perceived power imbalance between staff and service users led participants to view risk assessments as being overwhelmingly dominated by professionals and thus lacking accuracy and legitimacy. Moreover, despite a professed desire for change from service users, this dynamic generated feelings of passivity and lack of agency in service users, which likely detrimentally affected the development of effective therapeutic relationships. These accounts of mistrust and power differentials between service users and staff map well onto previous research in forensic settings (Mann et al., 2014; Shingler et al., 2018, 2020), in particular Shingler et al.'s (2020) theme of "*Feeling stuck, powerless, and out of control*," where prisoners described feeling powerless and lacking control over their own futures.

This sense of powerlessness and perceived limited power to disagree often led to participants in the study engaging in compliant behaviors to be seen as having insight and thus low risk. This process of acquiescence with professional views is reflected in Reynolds et al.'s (2014) descriptions of participants "playing the game," the findings of Dixon's (2012) study, as well as the prison

research by Shingler et al. (2020). In these studies, participants often disagreed with the content of their risk assessments but felt that expressing dissatisfaction could adversely affect restrictions or release decisions. Goulet et al. (2020) reported similar findings in a meta-synthesis of service users' experiences of involuntary treatment orders in forensic services, where participants in these studies feigned compliance and took on passive roles in the process to avoid undesirable outcomes such as hospitalization or further restrictions.

Some participants in this study felt they were viewed through an unduly negative lens with an excessive focus on past offending. They felt that any progress went unnoticed or was discredited and did not impact restrictions or progress them toward discharge. In Attrill and Liell's (2007) study, participants painted risk assessment as an unjust process, due to the emphasis on past actions rather than focusing on change, progress and strengths. Similar to the sample in this study, prisoners described feeling trapped by their past mistakes and wanted to feel understood by their assessors. Shingler et al.'s (2020) participants also felt that the past was heavily weighed upon and wanted more focus on the future. These criticisms are consistent with much of the research on mental health professionals' views which indicate that professionals often feel risk assessments are often not able to grasp the "*whole picture*" (Nyman et al., 2020, p. 106) of the service user and are often seen as overly focused on problems or risks (Levin et al., 2018). Common SPJ tools, such as the HCR-20, have also been criticized on the basis they fail to pay significant attention to protective factors or give any guidance on how to formally identify protective factors (Judges et al., 2016).

Limitations

IPA studies do not attempt to provide generalizable results and instead seek to elucidate individual accounts of a given phenomenon (Smith et al., 2009). Therefore, accounts from this study relate only to the participants of the study. As in all IPA research, it is important to recognize the researcher's subjective stance, and how this may have impacted the development of the study. Smith et al. (2009) outline how there may be multiple possible interpretations of the data and refer to IPA studies as a way for readers to attempt to make sense of the researchers attempts of making sense of participants' experiences. It must also be acknowledged that the balance of power lies with the researcher, as although this study focuses on hearing previously marginalized voices, it was the researcher who analyzed and interpreted these voices. For future studies, it would be beneficial to include respondent validation, to provide assurance that the voices have been accurately represented. However, given the power imbalances evident in FMH, care would need to be taken to ensure this was more than just a tokenistic gesture.

The fact that the researcher was working clinically in the service at the time the study was conducted can be viewed as both a strength and a limitation. To avoid any potential negative impact of this, a point was made to ensure only participants not clinically involved with the researcher were invited to the study. However, given the researcher was a staff member, it is possible that service users may not have been as open as they may have been with an external researcher.

Recruitment for the study was a challenge due to the small sample size to draw from within FMH services. This was further exacerbated by the COVID-19 pandemic which resulted in recruitment being temporarily paused due to the need to minimize face to face contact. Consideration should also be given to the potential limitation of volunteer bias, in that service users who took part may have clustered to extreme ends of the spectrum, e.g., those with excessively positive or negative experiences.

Relevance for clinical practice and future research directions

Although it is not possible to generalize results from this study to wider FMH settings, Polit and Beck (2010) have suggested that an informed reader can assess the degree to which the results may be applicable to other settings. With this in mind, clinical implications and directions for future research directions will be explored.

A key implication for practice concerns addressing the challenges of developing a therapeutic relationship in a coercive environment. In a systematic review asking general mental health service users about what risk assessment and management practices were most helpful, interpersonal relationships were a key factor which led to service users feeling included. Trust had an empowering value for service users, leading to mutual trust toward clinicians, and service users feeling less hesitant in sharing concerns (Deering et al., 2019). This is consistent with Dixon's (2012) findings, and the findings of this study, where the few participants who had built relationships and worked collaboratively with staff felt more comfortable to discuss risks.

It is not a straightforward task for staff to create a safe space where service users see risk assessment and management as part of their recovery and view working with staff as a key part of this (Rusbridge et al., 2018). In FMH, risk assessments in particular can be seen to have a negative impact on relationships, where staff can feel conflicted between being both the risk assessor and caregiver, and fear that difficult conversations will damage the therapeutic relationship (Gough et al., 2015; Levin, 2019; Nyman et al., 2020). However, evidence would suggest the opposite. For example, in Deering et al.'s (2019) systematic review, it found that when clinicians were transparent and offered a space for individuals to negotiate, a valuable shared understanding of risk could emerge. Service users described an increased sense of trust when staff

persevered despite differing views. Service users noted that staff acknowledging the tensions around risk conversations, as well as normalizing disagreements were particularly beneficial to support risk assessment and management practice (Deering et al., 2019).

Thus, in order to work toward building positive therapeutic relationships in FMH settings service users need to be educated about the risk assessment and management process. This could include an overview of the rationale for assessing and managing risk, the tools that are used and why, and explanations of why past offending is included in the assessment. Service users could also be given a chance to discuss how they might go about disagreeing with staff views, which could take the form of role plays. This may limit the tendency to acquiesce with staff views and increase insight that risk assessments can serve as a support to move forwards. Service users should be routinely involved in any development or updates on their risk assessment, be present at all risk assessment meetings, and invited to contribute. Although these conversations may be uncomfortable at first, the evidence suggests that this is beneficial for building trust and therapeutic relationships which may ultimately serve to enhance practice and reduce risk. The challenge of fostering relationships in FMH may be further supported by ensuring a trauma informed workforce. As discussed, the process of building trust and rapport can present challenges due to the often traumatic early life experiences of individuals in FMH settings. This can result in disrupted attachment styles which may make the formation of secure adult relationships more difficult (Mann et al., 2014). This would support staff to understand and recognize the contribution trauma may have had to the individual's difficulties and how to approach building trust and engaging the person, by being consistent, trustworthy, collaborative and non-judgmental, while maintaining clear boundaries.

A second implication for practice centers on striking an appropriate balance between risk and protective factors. The lack of attention to strengths was a prominent criticism of the process described by participants in this study and in previous research of service user and staff views (Attrill & Liell, 2007; Levin et al., 2018; Nyman et al., 2020; Shingler et al., 2020). This can lead to service users playing along in order to self-manage their risk status, as was the case in this study, and others (Dixon, 2012; Goulet et al., 2020; Reynolds et al., 2014; Shingler et al., 2020). There is a danger of services becoming overly focused on managing risk factors and compliance. A service-level preoccupation with risk may ultimately serve to enhance risk rather than reduce it (Markham, 2018). These criticisms from both staff and service users have likely contributed to the recent focus on the value of protective factors in risk assessment (Davidson et al., 2006; De Vries Robbé et al., 2011), which is a possible means by which this issue could be ameliorated. Several risk assessment instruments which include strengths

or protective factors have been developed as a result (e.g., De Vogel et al., 2012; Webster et al., 2006). The Structured Assessment of Protective Factors for Violence Risk (SAPROF) is an SPJ instrument that was designed to complement instruments such as the HCR-20. The literature has shown good inter-rater reliability and predictive validity for violent recidivism in populations of adult violent and sexual offenders (De Vries Robbé et al., 2011, 2015). The research has suggested that consideration of both risk and protective factors could enhance the predictive validity for violence when compared to considering risk factors alone (De Vries Robbé et al., 2013). If service users are encouraged to discuss what protects them, their goals and strengths, instead of an exclusive focus on risk, it may support to overcome some of the passivity and hopelessness experienced. This may in turn increase service users' motivation to participate in dialogue about potential future risks (Deering et al., 2019; De Vries Robbé et al., 2011). Thus, increasing the emphasis on protective factors may buffer risk by means of identifying strengths as well as facilitating conversations about domains of risk (Davidson et al., 2006).

Undeniably, the coercive and restrictive nature of FMH settings remains challenging. However, by attempting to be attuned to the factors which could support the development of therapeutic relationships, and incorporating protective factors as far as possible, some of these challenges may be limited. In addition to these suggestions for clinical practice, there is a wealth of future research that would be beneficial. The findings of this study serve as a starting point in understanding an under researched area. Given this research was confined to a low secure FMH setting, similar studies in other FMH settings, such as within forensic community mental health or high secure hospitals, would be beneficial. More specifically, this research could explore what service users find helpful about risk assessment and management, as to date this has only been explored in general mental health settings (Deering et al., 2019).

Conclusion

Despite the discussed limitations, this study has touched upon a population whose voices are frequently left unheard. Overall, the four superordinate themes were generally characterized by negative experiences of the violence risk assessment and management process, reflecting the complexity of risk assessment and management in FMH settings. Participants in the study described risk assessment in the context of being done to them rather than with them. Participants expressed feelings of powerlessness and hopelessness, compounded with a sense of mistrust toward professionals and lack of control over their lives. However, some positive experiences and attitudes were evident within the transcripts. Based on the findings of this study, and the literature discussed, it would appear that the implementation of collaborative risk assessment in line with the recovery

approach currently falls short of recommended standards. The authors hope that the current study has offered an account from which researchers and services can begin to consider both the challenges and positive aspects of service user experiences of risk assessment and management in FMH settings, which can be drawn upon when considering alternative approaches to practice or future research.

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