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FORENSIC MENTAL HEALTH SERVICES AS A RISK ESCALATOR

A CASE STUDY OF IDEALS AND PRACTICE

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FORENSIC MENTAL HEALTH SERVICES AS A RISK ESCALATOR
A CASE STUDY OF IDEALS AND PRACTICE

ABSTRACT

Medium/low secure units occupy a central role in forensic mental health care, bridging high secure and community services. Although outcomes, assessed in terms of readmission and identified reoffending, have been evaluated, little research exploring processes underlying attempted rehabilitation for offenders diagnosed as having mental health problems has been undertaken. The present qualitative study built upon previous research completed in a Northern England medium/low secure forensic mental health care institution for adults with learning disabilities (Heyman, *et al.*, 2002; Heyman, Buswell-Griffiths and Taylor, 2002). It was carried out in a medium/low secure forensic mental health care Unit located in London. In phase one, 43 staff, including general managers, doctors, nurses, psychologists and occupational therapists were interviewed about their philosophy of care, views about risk management for forensic mental health patients and perceptions of the Unit. In phase two, 10 case studies of patients were undertaken. As far as possible, patients were interviewed twice over a period of 11-20 months, and staff were asked about their progress. Two case conferences were observed. Data were analysed using the metaphorical concept of a rehabilitative risk escalator around three themes carried forward from the previous study: organisational issues; patient active risk management; and multiprofessional collaboration.

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FORENSIC MENTAL HEALTH SERVICES AS A RISK ESCALATOR

A CASE STUDY OF IDEALS AND PRACTICE

INTRODUCTION

This paper discusses the relationship between risk management ideals and practice in the complex world of forensic mental health care. This service caters for patients who are deemed to pose a risk to others, and possibly to themselves, on account, usually, of a record of serious offences against the person, and who are considered to have serious mental health problems. They are cared for within a health service framework, but are detained in accommodation offering various degrees of security.

The paper employs the concept of the health risk escalator (Heyman and Henriksen, 1998, pp. 94-103; Heyman, Griffiths and Taylor, 2002; Heyman, in press) in the analysis of themes arising from qualitative research conducted in a London-based regional secure unit (RSU). Impediments to the ideal of progressive treatment and rehabilitation of patients will be explored through consideration of patient and staff perceptions of three issues: organisational processes; patients' attempts to actively manage their own risk status; and multiprofessional collaboration. This introduction will briefly consider forensic mental health risk management in relation to the wider social science of risk, discuss the evolution of RSUs from a risk management perspective, and outline the application of the health risk escalator metaphor in this care context.

Late Modernity and Risk

Concern with risk management in the field of forensic mental health care is underpinned by a wider preoccupation with risk in late-modern industrial western societies. The conceptualisation of danger, recognised in all cultures, in terms of risk entails a historically novel mode of thought (Douglas, 1994). Pervasive societal adoption of a risk framework is motivated by a desire to control the future of real life processes which are too complex to predict other than inductively and probabilistically.

The status of this inductive risk framework is heavily contested, both in the wider society and in the social scientific literature. It may be viewed as a form of progress, replacing understandings of the future based on ideas of fate, magic or the will of the gods (Bernstein, 1996). However, its critics consider attempted colonisation of the future (Giddens, 1991) as hubristic, a view anticipated by Mary Shelley's *Frankenstein* in the nineteenth century. This new way of thinking increases public expectations that adverse events should be calculable and preventable, generating anxiety when control proves elusive (Beck, 1992). The attention paid to the concept of risk in late-modern societies reflects heightened anxiety about controlling the future. Hazards arising as side-effects of cumulative technological development appear to become ever more numerous, global and damaging, and less controllable and predictable. Such concerns compound more traditional fears about the fragility of the social order in the face of individuals, now conceptualised as mentally

disordered offenders, whose personal deviance cannot be framed in terms of culturally recognised motivations such as wealth accumulation.

In conditions of real life complexity, the natural science approach has to rely on inductive inference from averaged trends. In the field of forensic mental health care, this approach, discussed by Mcguire in the present volume, is epitomised by the actuarial approach to assessment of the risk of released patients re-offending (Monahan *et al.*, 2001). The actuarial approach aims to improve predictive accuracy by replacing clinical judgements about individual cases with empirically based inductive inferences about populations. Even

Monahan *et al.*, who have some faith in the power of multivariate models, accept that, *'at best, predictions will involve approximations of the degree of risk presented by a person, presented as a range rather than a single number, with recognition that not every person thus classified, even one accurately determined to be in a high risk group, will commit a violent act'* (Monahan *et al.*, 2001, p. 143). The quotation is tautological since, by definition, high risk (as against certain) events will frequently not occur. It also raises the question of where the dividing line between high and low risk should be set.

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As Mullen has commented, *'the language of dangerousness has been transmuted into the language of risk which has the comforting resonance of the actuarial, the calculable and the avoidable'* (Mullen, 2002, p.9), averaging the mystery of individual intentions into collective frequencies. Notoriously, actuarially based screening techniques generate high proportions of false positives and poor positive predictive values (the ratio of correctly identified to

higher risk cases), particularly for relatively unusual events (Gigerenzer, 2002) such as serious re-offending. (More accurately, false positives should be described as cases identified as higher risk which don't exhibit the index attribute. Inductively derived probabilities are applied to individual cases but can only be falsified in collectivities since an individual higher risk event may not occur, as noted above.)

Even the identification, let alone the prediction, of adverse events such as reoffending is notoriously difficult. To mention just one difficulty, those who reoffend but are not caught will not be included as positive cases in the databases from which models are induced. Of most relevance to the present paper, the implications of actuarial analysis for clinical rehabilitation are problematic. Identification as risk markers of unalterable attributes such as gender, age and childhood experience and offending history, and of dynamic but difficult to modify factors such as social isolation and use of illegal substances, work against the mission of safely rehabilitating offenders. In order to exit from their actuarially higher risk status, forensic mental health service users have to somehow compensate for these fixed or intractable indicators.

Risk Management in a Regional Secure Unit

The medium/low secure mental health unit in which the research discussed in this paper was carried out (the Unit) was established in 1996 in the context of Government policies which sought to move policy away from prolonged

detention of mental health patients in large asylums towards their care in the community. This shift, which began in the 1960s, did not wholly embrace mentally disordered offenders (Jewsbury and McCulloch, 2002). The Butler Report (Home Office and DHSS 1975) recommended a stepped approach to the release of high security patients and the establishment of regional secure units (RSUs) (DoH 2000), subsequently often referred to as medium secure units. The former term will be used in this paper because most such units contain accommodation offering a range of security levels, the calibration of which is not necessarily consistent between institutions.

RSUs were initially intended to provide a total of 1,000 places, a target which was eventually exceeded. By 1998, they contained over 3000 places, usually offering a mix of provision graded in terms of medium/low security, and hence psychosocial distance from the outside community. Acceleration in their development was associated with the Reed Report (DoH and Home Office, 1992), an extensive review of services for mentally disordered offenders. The report recommended a continuing commitment to community care, underpinned by strengthened interagency co-operation and multidisciplinary team working. RSUs aim to provide a progression between total confinement and gradually increasing freedom for patients as they move towards rehabilitation, a process potentially aided by their proximity to local communities and any sources of family support. The special hospitals remain, with only a modest decrease in numbers, from 1,700 in 1992 to 1,300 in 1998 (DoH, 1999), alongside the increasing numbers in RSUs, more of whom are becoming long-stay patients.

Hence, the main historical pattern over the last 15 years, in the UK at least, has been of forensic mental health service expansion rather than the substitution of low/medium for high security provision. The theme of risk assessment and control has assumed a pivotal role in these services, partly in response to Government fear that 'care in the community' has failed to ensure public safety (DoH, 1998; 1999; 2001), a concern driven by media-fuelled public anxiety about the threat posed by mentally disordered offenders (Laurance, 2003). This discourse of risk assessment tends, in clinical practice, to be about such people rather than with them, despite their status as patients (Langan and Lindow, 2004).

The RSU as a Health Risk Escalator

Some medically oriented research has assessed clinically defined need and/or outcomes for RSU users (Baxter, Rabe-Hesketh and Parrott, 1999; Friendship *et al.*, 1999; Coid *et al.*, 2001; Ricketts *et al.*, 2001; Edwards, Steed and Murray, 2002; Heap, 2003). Few studies of the attempted rehabilitation process in RSUs have been undertaken. The present qualitative study explores this process in its organisational context, drawing upon the metaphor of the rehabilitative risk escalator.

A health risk escalator has been defined as *'a system, designed or emergent, which is oriented towards managing a defined health risk, and which is made up of a set of sub-systems, ordered in terms of different trade-offs between*

autonomy and safety, through which service users may move' (Heyman, in press). To operate as a risk escalator, a health care system must be seen to possess three qualities: differentiation of steps in treatment regime in terms of the degrees of risk severity they are designed to manage; attempted congruence between varying levels of safety/autonomy balance and assessed client riskiness; and the potential to move individuals up towards increased safety (for self and/or others) and down towards greater autonomy. These features are not meant to be read as objective features of a risk escalator, but rather to draw attention to a tacit, shared view of complex risk management social systems predicated on complex, unarticulated judgemental processes.

The risk escalator concept can be applied to a wide range of health care risk management systems, e.g. the system of screening, diagnostic testing and pregnancy termination designed to reduce the risk of babies being born with chromosomal abnormalities (Heyman and Henriksen, 2001). This system provides an example of an 'upwards' risk escalator, as the initial stage, serum and other forms of screening, identifies a higher risk sub-group who are offered a more intense procedure, diagnostic testing which may lead to the offer of a termination at the next level if fetal chromosomal abnormalities are identified. Upwards risk escalators are susceptible to iatrogenic positive feedback, as the identification of risks trigger procedures which themselves carry risks. For example, miscarriages can be caused by amniocentesis administered to women who are not carrying a baby with chromosomal abnormalities but screened positive, i.e. as being at higher risk, via less accurate but non-invasive testing.

The concept can readily be applied to rehabilitation through an RSU, a 'downward' risk escalator which aims to gradually progress patients from safety towards autonomy in relatively small, easy stages. Patients who learn how to cope successfully with a small amount of autonomy are offered a little more until, eventually, their presumed riskiness is reduced to levels low enough to make discharge an acceptable risk. Given the nebulousness of risk status assessments, particularly in the field of forensic mental health care, downwards risk escalators are susceptible to charges both of unwarranted therapeutic optimism and unnecessary conservatism. For a more detailed discussion, see Heyman and Henriksen (1998, pp. 94-103) and Heyman (in press). A diagrammatic representation of the Unit, which was continually reorganising during the data collection period, at one point in time as a risk escalator is provided in Figure One below.

Insert Figure One here.

The quotations presented as data will be mapped onto the structure represented in Figure One. The small within-unit steps displayed in this figure were not formally recognised in the Unit. However, some staff perceived these small differences in the autonomy/safety balance as corresponding to a matching calibration of (presumed) riskiness.

METHODOLOGY

The present study was modelled on previous research completed in a medium/low secure forensic mental health facility for adults with learning disabilities (Heyman, Buswell-Griffiths and Taylor, 2002). The Unit, located in a deprived inner-city area of London, provides care for about 100 patients, around 90% male, and has a large proportion of individuals from diverse ethnic minorities amongst its patients and junior nursing staff. The largest, non-majority groups, both among nurses and patients, are of black African and Caribbean origin. The study was designed in two phases, with fieldwork undertaken between 2000 and 2003. In the first phase, 43 staff interviews, with general managers (2), qualified (19) and unqualified (7) nurses, psychologists (3), occupational therapists (3), social workers (3) and doctors (6), were carried out in order to explore staff views about the Unit, and to guide directions of enquiry for a second phase. The sample included 11 senior managers, who worked across ward-based and community services, with at least one at this level from each profession. Three nurse respondents were entirely community-based.

Managers and medical staff all consented to be interviewed, apart from one consultant doctor who declined on account of pressure of work. Front-line staff were recruited through requests to volunteer. They were therefore self-selected. Nurses on one ward expressed suspicion about the purpose of the project and declined to become involved in the phase one interviews, although one of these nurses agreed to participate in a case study. The sample provided a range of views about the RSU, as will be seen below, but

these opinions were not intended to be, and were not, necessarily representative of RSU staff views.

The second study phase involved intensive case studies with 10 patients. Case studies included, at most, two interviews with each patient, with the second undertaken after 11-20 months, interviews with the staff involved in their individual care, and observation of case conferences. Patients at different RSU locations were identified in discussion with ward managers and invited to participate. Four selected patients over and above the 10 mentioned above were not included, two because they declined, one on account of concerns that participation might interfere with therapy, and one because he was judged too dangerous to be interviewed privately. After their first interview, patient respondents were asked if the interviewers could speak to their professional carers, attend a case conference and revisit them later. One case study patient did not want any staff interviews, and another consented only to a nurse manager being interviewed for the case study. One member of staff refused to participate in case studies. Sixteen staff were interviewed, providing staff views for nine of the 10 case studies. Two case conferences have been attended and recorded, and five patients have been revisited for a progress update. Of the other five patients, four were discharged during the study period and one died. As with staff interviews, the case study respondents offer a range of trajectories and views, but do not necessarily represent those of the overall RSU patient population.

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Lightly structured phase one staff interviews were organised around the following topics: the aims of the Unit and their own role; what works well and barriers to the delivery of high quality care; issues arising from patients' movements through the wards; accounts about anonymous patients who had progressed well or not progressed well through the system; and formal and informal risk assessment processes. Data collected in phase one informed the topics covered in phase two. In phase two interviews, patients were asked about the following issues: how they were getting on; what moves they had made backwards or forwards through the wards, and how the moves had come about; how they spent their time; what they considered good and not good about their care; how they viewed their future; and what risks were reduced or increased by their residence at the Unit.

Interviews, undertaken by three of the authors of this paper, and case conferences were taped and fully transcribed for analysis around thematic categories. They are quoted verbatim, with respondents identified through pseudonyms. Information which might identify an individual has been removed. Frequent visits and informal contacts with Trust staff allowed the researchers to absorb some of the cultural milieu of the Unit. Seven presentations to Trust staff have been held, generating discussions which have yielded further insights into perceptions of care and multidisciplinary working in the Unit. The research was approved by the NHS Local Research Ethics Committee. Participants received a printed information sheet and consent form.

Interview and case study transcripts were coded thematically. Coding was undertaken concurrently with data collection, so that subsequent interviews could explore emergent themes. Data interpretations were checked through frequent discussion of independent analyses of the same transcript carried out by members of the research team. Feedback arising from presentations to Trust staff provided another method of checking thematic interpretations. However, their credibility depends primarily on the reader's judgements about the analysis of qualitative data presented directly in the paper.

DATA ANALYSIS

Qualitative data, drawn primarily from interviews with staff and patients, will be used to highlight critical issues associated with the operation of the Unit as a downwards risk escalator. The researchers were only able to observe the system in operation to a limited degree. Nevertheless, comparisons of comments made by staff and patient respondents at different locations within the organisation allowed the ideal-typical representations of risk management to be related to emergent problems. The ideal-typical will be reviewed in terms of three issues, organisational processes, patient perspectives on risk management and multiprofessional collaboration.

The Ideal-Typical Risk Escalator

The two quotations given below, provided respectively by a senior manager and doctor, illustrate ideal-typical perspectives on the potential for risk reduction and rehabilitation in forensic mental health services.

The current proposal of a medium secure service is that we should take someone who has committed an offence whilst they have been unwell, and bring them in here and be able to, it could be that it is homicide, but bring them in here, and be able to put them back in the community somewhere around 18 months to two years ... [The RSU] provides a step-down unit for high secure hospitals, and we provide a sort of step-up service from local secure PICUs. [Psychiatric Intensive Care Units] ..., and those hard to manage patients who are in, say, generic psychiatry. (Graham, RSU general manager, phase one interview)

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This manager's therapeutic optimism may have been associated with him having recently joined the Unit at the time of the interview. He left the Unit about two years later to take up another post. The quotation locates the Unit in an elongated health risk escalator, as a sub-unit within a larger multi-organisational system, the whole representing a stepped progression in care offering different autonomy/safety balances. Additionally, the quotation radically uncouples the length of stay in secure units from considerations of retribution and criminal justice. From a risk management perspective, as this respondent argues, offenders whose crimes were caused by a mental health condition shed their high-risk status if they are cured, and should, therefore, be released. The respondent illustrated the point with the hypothetical

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example of a patient who murdered his mother in response to the specific delusion that she was trying to kill him. If the delusion could be cleared up through the use of psycho-pharmaceuticals, the patient would no longer have high risk status, and could be released. Although the short time rehabilitation period cited reflects standard policy positions (Snowden, 1990; Reed, 1997), the point at issue is not the time frame but a perspective which prioritises risks arising from mental health problems rather than criminality or justice.

The next quotation offers an ideal-typical account of a multi-faceted rehabilitation process.

I think medication is very important ... There was one patient who killed his dad. And he was so psychotic, and he was medicated, and he was no longer psychotic. But then he got depressed ... and psychology was very important to help [him] see what he has done, and come to terms with what he had done ... I think occupational therapy is very important for lots of people ... cooking skills, health care, trips to the community. And social work ... accommodation and benefits. (Neelam, MSU senior house officer (SHO), phase one interview).

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SHOs were younger, non-specialist doctors working on rotation. The view of rehabilitation expressed above suggests a progression of qualitative phase shifts in each of which a particular profession would play a lead role on account of its specialist knowledge base. The process starts with physical treatment of a disease, works through psychological issues, takes up daily

living skills and finishes with the establishment of links to the outside community. Nursing is noticeably absent from this list, however, even though nurses make up by far the largest segment of the workforce in the Unit, and patients spend a much higher proportion of their time with them than with other professional groups. The diffuse, holistic and integrative role of nursing in this ideal-typical account of rehabilitation, perhaps, cannot be so easily defined by doctors whose interactions with them may be rather limited.

Organisational Processes

Rehabilitation was delivered by a complex organisational structure which included multiple professions who needed to collaborate, wards within the Unit, the NHS Trust of which the Unit was part and interfaces with external service providers. The effective operation of the Unit as a downwards risk escalator could be undermined by disjunctions between any of these elements.

The analysis presented below will focus on accounts of the Unit's operation obtained in research interviews. Involvement with the Unit generated a wealth of additional information which did not register in interviews or observations of case conferences. The Unit was affected by rapid staff turnover and shortages, reliance on agency employees, staff ethnic affiliations and divisions, repeated serious untoward incidents, defective patient safety systems, a blame culture, accusations and rumours about professional misconduct, frequent removals of staff deemed to have failed and

interprofessional rivalries. However, our analysis of organisational processes will focus not on these serious surface manifestations of social disarray, but on underlying tensions within the architecture of the rehabilitative risk escalator. These tensions interacted with, but also fuelled, conflict within the Unit and between the Unit and other agencies. Their main effect was to open up disjunctions between a patient's perceived risk status and their closeness to discharge.

Unlike many physical escalators, the metaphorical risk escalator contained multiple entry and exit points, an architecture which complicated the management of individual patient trajectories.

In theory, you know, we can take people from the community who have come in on a section three [of the Mental Health Act, allowing compulsory preventative detention for the protection of the patient or others in some circumstances], or we can take people from special hospitals, and we can take people back from other regional secure units or medium secure units. And so there's several different routes. They don't necessarily have to come through the admission wards either. They can go straight to the continuing assessment support ward, or they could, in theory, go straight to the rehab wards, so only the most disturbed people would come here. (Martin, ITU manager [nurse], phase one interview)

This respondent had recently been moved from a rehabilitation ward to the ITU, a move about which he expressed considerable unhappiness in informal conversations. He also criticised the Unit quite severely, for example for poor ward design. Shortly after the interview, he was asked to relocate to a remote community team. The term *'in theory'*, repeated twice, conveys his distanced stance from the Unit regime. The relatively mild comments quoted suggest that the existence of multiple entry and exit points complicates the achievement of congruence between the assessed riskiness of patients and the autonomy/safety balance.

Problems occurred if patients judged too difficult to manage in a medium secure facility were admitted for financial reasons.

Because of the overspend, we have to bring back people who are much more ill, and I think that has really contaminated some people's rehab problem. (Norman, RSU nurse manager, phase one interview)

The overspend refers to the Trust's financial deficit which was partly offset by obtaining revenues for extra-contractual patients whose illness severity adversely affected the rehabilitation of others. The quotation illustrates the tension, discussed further below, between a risk management framework focussed on the rehabilitation of individuals and the requirement to care for patients in groups. At the other end of the risk continuum, the Home Office could be viewed as excessively cautious, perhaps held back by the mass

media fuelled political imperative to avoid any serious untoward incidents involving discharged forensic mental health patients.

Sometimes these consultants send off the team [report] very quickly, right, requesting the leave and an update, blah blah, but the Home Office, tends sometimes to drag their feet on these things. So it is not always the fault of the [consultants]. (Craig, LSU staff nurse, phase one interview)

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At the time of the interview, the LSU had just been built, and smelled of new paint. It's garden had not (and still has not) been completed. Patients who change medical officer have to reapply for leave entitlement, as had happened to all those on this new ward. The temporary suspension of leave and the lack of a location for outside exercise may have exacerbated patients' claustrophobia, making Home Office delays even more frustrating than they might otherwise have been.

The following instructive quotation illustrates an organisational response to the underlying risk management dilemma of balancing autonomy with safety.

We have too many stages. So you have an intensive care [ward] ... Then, from intensive care, they [patients] go into admission ward, and they spend another period in the admission ward, and sometimes it is too long. From the admission ward they go to the first of the rehabilitation wards, as you say, and I am not sure how focussed they are in terms of

rehabilitation. And, from there, they go to another form of rehabilitation ward, which is, could be said to be, a form of pre-discharge ward. And they send them to the pre-discharge for a period. And then, somehow, some of the patients are transferred ... to a further pre-discharge ward which is outside this unit ... before going into the community. But now we have opened a low secure service, because of the sensitivity, and, I think, people's anxieties. They feel, 'Well, I'm still not sure. I can transfer them to this one'. (Graham, RSU general manager, phase one interview)

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The decision to discharge, or recommend discharge of, a patient required clinicians to make a critical judgement about the safety/autonomy balance. Detaining a patient might unnecessarily, and expensively, curtail their autonomy. Releasing them might result in re-offending for which the risk manager would be held responsible. The above respondent suggests that managers postponed these difficult decisions by elongating the risk escalator, adding further rehabilitation stages. This elongation would simply push back the critical decision about when, if ever, to release a patient.

A second tension was observed between individual progression and group care. Although the risk escalator metaphor focuses on the risk status of individual patients, they were cared for *en masse*. This contradiction generated a tension between moving a patient up or down the risk escalator according to their risk status and managing the Unit as a collectivity. A lack of spare capacity, arising both from high demand for beds and financially driven pressure to fill them, entangled patients in chains of movement. Patients could

not move down or up the system unless an appropriate place was vacated which, in turn, required more spaces to become available further up or down the system.

Well there's the decision process about the patient and there's also decisions are made on the basis of where spaces are sometimes.

(Pamela, RSU psychologist, phase one interview)

Psychologists belong to the multidisciplinary teams which make recommendations about patient progress, but are not involved in ward or bed management. Decisions which they have been party to may be overruled by the bed management team which is made up of doctors and nurses only. Blockages occurred frequently in relation to discharge, which required the provision of suitable accommodation by external agencies.

I want to be free. I have been doing self-catering for three years. I am not a danger to myself. I am not a danger to anyone. I'm not getting my accommodation. They are not getting me anything. (Daniel, patient in CASU who is eager to be discharged, case study interview)

Daniel cited his accomplishment of self-catering as evidence of his low risk status. This association may derive from the model of rehabilitation articulated by the Senior House Officer quoted above, in which medical, psychological and then daily living skills are progressively dealt with. Incongruence between

his self-defined risk status and his position on the risk escalator (in our terms) delegitimated the health care regime for Daniel.

Lack of control over patient admissions and discharges resulted in staff having to manage patients with widely different needs within the same ward.

The [ITU] ward is more like, half of it is more like, a rehab ward. They have three patients there that are waiting to go off to special hospitals and are blocking beds. They have four patients that need acute care, need intensive care. So, because they have three bed-blockers, that turns some of our beds into very acute care beds, not through choice but through necessity. (Beverley, MSU admission and assessment ward manager [nurse], phase one interview)

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The above respondent had resigned at the time of the interview, having been criticised for attempting to send difficult cases back to ITU where care was more expensive. She suggests in the quotation that blockages distorted the care system, in this case requiring staff to manage rehabilitation and acute care within the same ward environment. Conversely, movements motivated by inter-individual considerations could cause comparable distortions.

Interviewer: *What happened that meant that you moved?*

Patient: *Well I had a fight with a patient over there. Another patient on the ward was fighting.*

Interviewer: *Oh right. So it was about splitting you up?*

Patient: *Yeah. Well not only that. It was progress. It was the [only] progress I'd made since I'd been on that ward.* (Ian, patient in rehabilitation ward (MSU) who had been cycled between less and more secure accommodation several times, phase two interview)

This patient had been confined in secure mental health services for many years, perhaps as a result of his belligerent attitude rather than the severity of his original offending. He had progressed as far as a pre-release ward, but had broken the terms set by the parole board for his release. His possibly ironic reference to '*progress*', in our terms down the risk escalator into a ward closer to the community exit, had been undertaken in order to prevent him and another patient from fighting. This example clearly illustrates the tension between caring for groups of patients and generating individual trajectories based on risk assessment.

Organisationally derived blockages and movements which weakened the congruence between patients' risk status and their position on the risk escalator weakened the Unit's therapeutic legitimacy.

I think sometimes patients here are very frustrated ... We get all sort of grades of patients. Some would see themselves as, you know, 'My index offence is less than yours, so why am I still being stuck here?' ... We can't move people due to the pressure of the service. (Norman, RSU nurse manager, phase one interview)

Patients assessed their risk status, and therefore the appropriateness of their position, in various ways. For example, one patient compared his dose of 200 mills of Haliparidol with that of a patient peer on 300 mills, concluding that he was less ill, and should, therefore, be allowed to move on. The patient quoted below justified his rapid progress by comparing his relatively low drug dose with those received by other patients.

Interviewer: *So your progress through some of the wards has been very quick, and the progress, the speed of others has been slower. What do you think the difference is between –*

Patient: *Because their illness is greater than mine ... because my illness is treated by three milligram of Respiridon. It is a very low dose ... So my illness is controllable easily.* (Hassan, patient in rehabilitation ward (MSU) who had progressed quickly towards rehabilitation in comparison with other patients, case study interview)

This quotation in a forensic mental health care context implicitly conflates mental health, as indexed by drug dose, with risk status. However, this patient's lower drug prescription may have been associated with him not posing ward management problems. At the time of the interview, staff were questioning whether Hassan could be safely discharged.

Blockages leading to perceived incongruence between risk status and position on the rehabilitative risk escalator could generate a vicious circle, fuelled by positive feedback, whereby a patient's failure to move on caused

them to react to the resulting frustration in ways which reinforced their higher risk status.

It confines and spirals a patient out to be on a high security ward for too long. It's too confining and probably ... causes more difficulties of rebellion and pushing against the structure. (Patrick, MSU social worker, phase one interview)

In order to avoid this vicious circle and consequent delays, patients had to exercise extraordinary patience.

Interviewer: *Have things changed the way you want them to have done? Are they going as you would have liked?*

Patient: *Yeah ... Couldn't go any better really.*

Interviewer: *Is there anything that you would have liked to have done different?*

Patient: *Well, ... the length of time really. If it had been quicker, it would have been better. And that is the way it goes, you know? Just got to sit back and be patient, you know. (Stan, patient in a rehabilitation ward who has lived in secure institutions for over 15 years, and has progressed steadily towards rehabilitation in the last few years, phase two interviews)*

Staff viewed this patient with suspicion, in part because of his overwhelming compliance and positiveness about the Unit. They had given him the

sobriquet of 'The Star Patient'. This theme, that patients might earn, or at least attempt to earn, rehabilitation by temporarily accepting a compliant role will be considered further in the next section.

Patient movements, whether linked to an individualised risk assessment or not, could disrupt established relationships.

I mean, it's sad moving home. In fact, it [changing ward] is moving home, which is the most stressful thing in life. And, of course, once they move, there is no real way to contact their friends or staff ... That's why I think more effort should be made for the care patients get to be changed. It seems to be done very haphazardly ... Sometimes, somebody will be told, 'Oh, you have to move in a matter of a couple of days'. (Bella, nursing assistant, MSU admission and assessment ward, phase one interview)

This issue can also be analysed in terms of the tension between individualised patient rehabilitation trajectories and care *en masse*. Patients undertake solo journeys towards rehabilitation, but live in communities from which they can build up social support networks. Junior nurses like the above respondent who interacted more frequently with individual patients may be more aware of the personal cost of relocation than are their seniors who decide patient movements.

Patient Self-management of Their Risk Status

Models of risk assessment, whether actuarial or clinical, tend to discount reflexivity. Patients are treated as judgemental dopes whose behaviour reveals their underlying risk status diagnostically. However, risk assessment impacts significantly on their life prospects. In particular, being assigned to a lower risk status makes an earlier release more likely. The following quotation illustrates a patient's awareness of the information game involved in risk assessment-based rehabilitation.

I mean, I was here, and I played the game the right way. That's to keep quiet and wait, you know, to get better. (Tom, CASU patient who has lived in secure institutions for over 20 years, phase two interviews)

Tom had previously resided in prison, high security and private units for over two decades. His account conflates information game playing with improved mental health. As the former, if it works, generates a change towards lower risk social status, this conflation was reinforced by the operation of the rehabilitative risk escalator. Moreover, to the extent that mental disorder is a social status rather than a personal condition, better mental health, and therefore reduced risk status in a forensic context, may become self-validating. The following quotation, similarly, adopts a grudgingly accepting but challenging stance towards the conflation of rehabilitation with learning to conform.

Patients get worn down really, not really being cared for. But you're beating your head against the wall so many times, so you just accept what's going on. It's not really that you become all that better. You've just accepted what's going on ... I think it's just a case of getting used to the environment, or the rules and regulations. (Kunle, charge nurse, CASU, phase one interview)

The above respondent differentiated the achievement of mental health from becoming accustomed to rules and regulations. He cited this gap as evidence for an institutional failure of care.

The systematic rewarding of patient conformity confounded risk assessment which, for patients who sought to be discharged as quickly as possible, could become an element in an information game. Staff attempted to peer underneath this lower risk surface by observing patients in testing situations, itself a risky procedure.

Nurse: *I personally think, when he goes out [on leave], that's a big test for him, because he goes out on a Saturday to [large town], and [town] is quite far, and anything can happen then ... If something really pushed him, he would do something ...*

Interviewer: *... What plans do you have in place for the future for Stan?*
...

Nurse: *... I think he is going to be here for a long time. (Letitia, primary nurse for MSU rehabilitation ward patient Stan, phase two interview)*

This patient had been given a life sentence. He was currently allowed out during the day, but had to return to secure accommodation at night. The notion of a *'test'* suggests that leave was used to give patients opportunities to transgress, hopefully in relatively minor ways, so that a more ecologically valid assessment of riskiness could be made. His psychologist was concerned that Stan was suppressing anger, and that the managed environment of a secure unit provided little scope to test his self-control. He had responded fairly calmly to the termination of a close relationship, but the psychologist did not feel that this reaction provided a sufficient test of his riskiness. The nurse respondent expressed a lack of confidence in the test procedure outlined above, perhaps on account of its obvious flaws: first, that patients might conceal their riskiness temporarily, whilst on leave; and, secondly, that they might commit a serious offence. However, there is no obvious escape from this risk assessment dilemma. The measures which make an RSU a safe environment also obscure patient riskiness. The respondent, in response to an interviewer query, checked with a more senior nurse, and found to her surprise that Stan was marked for eventual release. This incident illustrates how a patient's rehabilitative prospects could become ill-defined through being calibrated both amnestically, in terms of their past offending history, and through complex judgements about their present underlying risk status.

Instead of conforming in order to speed their release, patients might act, consciously or not, in ways which prevented them from moving down the risk escalator towards release.

One has been here six years. The other person has been here three years, I think, um, and both have moved towards discharge, and ... something has happened, you know. They have become unwell. They, um, harmed themselves or something. And I think that is when it is often about the anxiety. But, of course, the longer people stay, the more anxiety they often are going to have about then going into leaving, because it becomes a little world on it's own here. (Sylvia, MSU psychologist, phase one interview)

Staff recognised the phenomenon of 'gate fever'. Gate fever could create its own vicious circle if patients managed their anxiety about re-entry to the outside world by adopting delaying tactics which led to further delays, increasing their anxiety still further. This phenomenon posed a challenge for risk management which was not always taken into account because previously compliant patients could suddenly become unsafe. This psychologist's sense of the Unit as a '*little world*' may be associated with her being new to her post at the time of the interview, and seeing herself as an outsider. She felt that Unit staff were organisationally risk-blind to gate fever and to other issues linked to offending, for example to the aetiological significance of illegal drugs and alcohol use which were not systematically addressed in the Unit.

As well as arising from institutionalisation, gate fever could be associated with patient concerns about their external circumstances.

Boyd became acutely agoraphobic. Even if we wanted to, we wouldn't have got him out of the front door because, as far as he was concerned, he had been on the six o'clock news. And, you know, there were wanted posters of him up all over [local borough]. That actually felt quite genuine. (Jim, CASU psychologist, case conference)

Boyd had asked at his annual review for his case not to be taken to the Home Office Tribunal, and that he should become a long stay patient. The above quotation documents the negative impact of media selective attention on rehabilitation. This account demonstrates that resistance to discharge could arise in response to external ecological conditions as well as from the psychosocial process of institutionalisation.

Finally, some patients were determined to get themselves readmitted to prison so that they could escape from an indeterminate sentence, and also, possibly, from being located in a framework of psychiatry and mental health care.

There was a patient on the ITU who was insisting on being sent back to prison. He didn't want to stay here, and he actually told the team that he faked all his mental illness, you know. According to us, he had heard voices. He told the doctors when he was assessed that he was hearing voices, and, you know, he ... [ended up] assaulting a medic seriously.

He was sent back to prison. (Adam, MSU admission and assessment ward manager [\[nurse\]](#), phase one interview)

Patients reflect on their risk assessment and attempt to actively manage their risk status. They may deliberately act in ways designed to move them into a lower or higher risk category or to move in or out of the status of mental health patient.

MULTIPROFESSIONAL COLLABORATION

As illustrated by the quotation from a Senior House Officer quoted towards the beginning of the Data Analysis section, the successful operation of the rehabilitative risk escalator presumed that effective multiprofessional collaboration could be accomplished. This section presents a brief pen portrait of multidisciplinary working in the Unit. Organisational issues associated with the multiprofessional context will then be illustrated in relation to the operation of the Unit as a rehabilitative risk escalator.

Patients received services from doctors, psychologists, qualified and unqualified nurses, occupational and art therapists, social workers and teachers. These differently sized groups participated in multidisciplinary case conferences which reviewed patients' risk status, location within the system and discharge prospects. Numerous tensions existed between professions which viewed care and rehabilitation differently. For example, nurses sometimes expressed a lack of sympathy towards doctors who were

assaulted because they considered that doctors could be arrogantly risk-blind about their own personal safety. In turn, other professions sometimes criticised nurses for being overly concerned with custodial issues.

Each profession had its own internal reporting system which cut across Trust boundaries, complicating multiprofessional collaboration. For example, nurses reported ultimately to the Trust level Director of Nursing Services for whom the Unit represented only one portfolio element. The Director expressed frequent concerns about nursing professional standards. She considered that nurses' poor risk management led to frequent failures to prevent serious untoward incidents. Constant organisational and personnel change complicated multiprofessional collaboration, since, as illustrated below, staff struggled to reorient themselves to shifts which occurred outside the world of their own professional group.

Nurses provided most day to day contact with patients, whilst the other professions offered intermittent contact through maintaining caseloads. However, as generally happens in this treatment context, frontline nurses who interact most frequently with patients have a relatively low organisational status. This was seen in the two case conferences which the researchers observed. A nurse was invited to introduce the case, but made little further contribution to the discussion. Nurses sometimes felt that their judgement about the riskiness of patients were discounted even though they were based on directly obtained holistic knowledge of individuals rather than intermittent scanning of a caseload. At the same time, some considered that their

frontline role made them vulnerable to scapegoating when adverse events occurred. This issue raises the question of acceptable risk versus negligence, almost invariably posed in retrospect after an adverse event had occurred, and mostly directed at nurses on account of their daily caring role.

The social worker cited below put effective multiprofessional collaboration at the centre of effective working of, in our terms, the rehabilitative risk escalator.

I think, for me, you can't beat a stable multidisciplinary team ... professionals from various backgrounds, nursing, education, therapy, psychology, all coming from different viewpoints. And if there's honesty and respect there, there's the ability to challenge ... I think that's the baseline within the Unit. (Patrick, MSU social worker, phase one interview)

Patrick had resigned from the Unit because his workload, which had been increased to include more community placements as well as an MSU caseload, had become, in his view, too difficult to manage. The reference to '*honesty and respect*' raises the question of collective relationships between professional groupings which differ in status, remuneration and social power, each with its own variant on the wider cultural world view. Systematic analysis of this complex issue goes beyond the scope of the present paper. In relation to analysing the operation of the Unit as a risk escalator, it is sufficient to note that achievement of multiprofessional collaboration was problematic, and, at best, fragile.

Probably, what is lacking is the lack of communication among disciplines ... I would appreciate if there was some more feedback being given after, as soon as the [therapy] session is finished ... So, that would probably, you know, would help in evaluating the overall care of the patient.
(Frederico, MSU rehabilitation ward staff nurse, phase one interview)

Constant staff changes at all levels, fuelled by regional labour shortages and purges, made the always delicate task of attaining multiprofessional collaboration even more problematic.

Management here is like a tide. It comes and goes out, and we have almost three-monthly tides that are management changes ... Since I have been here, I have had five different managers in two years, yeah. And I have had five different views, and five different opinions which I have to implement. So, when there is inconsistency with the management, there is inconsistency with the approaches that we will use. (Beverley, MSU admission and assessment ward manager [\[nurse\]](#), phase one interview)

As noted above, Beverley was herself part of the management 'tide'. This interview took place just before she left the Unit to take up another post following a reorganisation. She had been criticised, and felt that her position on the Unit was vulnerable. The next quotation articulates the inhibitory impact of endless staff changes on multiprofessional collaboration.

MDT [multidisciplinary team working] has been difficult. There have been a lot of staff changes, and there has been a lot of instability within teams. And that's, I think, one of the reasons why it has been very difficult developing a philosophy of care and way of working (Richard, CASU psychologist, phase one interview)

Richard, who was part of a new multidisciplinary team at the time of the interview, left the Unit shortly afterwards, disillusioned on account of the problems he refers to. The wider blame culture in which forensic mental health services currently have to operate could generate a condemnatory atmosphere between professional groups, encouraging a procedure-bound approach, and inhibiting risk-taking.

The protocols and everything are quite rigid, and there is also the blame culture. The nature of nursing is that if you do something wrong, you are blamed. 'Why did you do that? You should have taken an escort, and the patient ran off', and this and that. Obviously, the pressure comes from up top. The pressure comes from them in the community, the politicians, maybe the Home Office. There is a lot of pressure that filters right down ... it is against taking any risks, but that stifles the whole nursing thing of using your initiative, trying new ways and all that. (Kunle, CASU charge nurse, phase one interview)

Nurses were particularly exposed to the risk of blame on account of their generic role in sustaining the rehabilitative risk escalator.

DISCUSSION

The present study was undertaken in one RSU, with its own specific characteristics, particularly an ethnically diverse, socioeconomically deprived catchment area, financial instability and organisational turmoil. The findings of a case study can only be generalised in relation to its particular attributes. However, the emergent issues closely resembled those found in a study of a medium/low secure institution located in Northern England. The latter unit differed from the present research site in many respects, including a client group with learning disabilities, rural location, the mono-ethnicity of its staff and patients, and a low staff turnover in an area of relatively high unemployment and stable population. The two units also differed in their organisational history. Researcher questions to senior staff about who had designed the North of England institution generated wry amusement. Its sub-units had evolved independently to offer different balances of safety versus autonomy, and had subsequently been coalesced into one risk management system. The London RSU, in contrast, had been consciously designed by a senior psychiatrist to provide a progressive system of rehabilitation. However, its architecture had been frequently modified, for example to incorporate additional stages of rehabilitation, as noted above.

Interviews with participants offer only limited insights into underlying processes of risk management, accounts of which may be idealised or reflect disillusion, depending upon the stance of the staff or patient respondent. However, putting together multiple perspectives can, perhaps, generate an insightful picture of the overall risk management system. The crises and scandals which we were aware of in the London Unit did not surface in research interviews, a strong limitation of this data collection method. But more fundamental problems which we have interpreted in terms of the architecture of the risk escalator emerged clearly in both settings.

Underlying the relative calm of the North of England institution and turmoil of the London RSU were similar issues arising from their operation as downward risk escalators, namely processing problems such as blocked chains of movement, difficulties for risk assessment and management arising from patients' strategic attempts to control their risk status, and reliance on the mostly unfulfilled accomplishment of multiprofessional and inter-organisational collaboration. The most noticeable outcome of these problems was disjunction between perceived risk status, however assessed, and location on the rehabilitative risk escalator, a disjunction which undermined its therapeutic legitimacy.

Consideration of these organisational issues raises the question of the implications for service development of research which has explored processes of risk management in RSUs. The National Service Framework for Mental Health (1999) recommended increased provision for mentally

disordered offenders at all levels of security. Although the problems identified in the present research appear rather intractable, the outcomes can hardly be worse than those of the prison system for this client group. Moreover, follow-up research with ex-patients from the Northern England service (Heyman, Griffiths and Taylor, 2004) suggests that the frustrations, delays and setbacks associated with the in-patient experience may be viewed more positively in retrospect, even by patients whose re-entry into the community had failed.

Reflection on an overall health system can identify areas where critical attention might enhance risk management. For example, the interconnected nature of patient movements leads to blockages if any link in the chain is broken, just as in the UK housing market. One way of reducing the number and length of chain blockages would be to fund spare capacity in RSUs.

Although the present paper has adopted a resolutely organisational approach, the resonances between the withholding of progress and patients' personal biographies, which often include abuse (Coid, 1992) as well as offending, should not be overlooked. Patients whose ability to form and sustain attachments has been disrupted by traumatic childhood experiences are expected to manage separation from external personal support networks, if any, frequent terminations of relationships with patient peers and staff. They are required to relate to a transient and disturbed peer group and to staff whose limited engagement with them is a form of work (Adshead, 2002). The RSU needs to be considered as the community in which patients spend a

significant portion of their lives. As in any human community, members' quality of life will depend upon the supportiveness of their social networks.

A third issue worthy of developmental consideration concerns the tension between individual risk assessment and care for patients in groups. For example, patients might be 'promoted' simply to separate them from others even though they had not earned a reduction in their risk status. The tension between care for patients in groups and the ascription of risk status to individuals requires critical consideration.

Fourthly, the paradox of risk assessment in secure settings needs to be critically addressed. By preventing offending behaviour, RSUs make its assessment more problematic. Actuarial methods cannot offer a reliable guide to the safety of the rehabilitation of individual offenders who by definition will exhibit high risk factors. The present research suggests that risk managers may in practice assess risk in terms of compliance, or test behaviour in conditions of presumed greater ecological validity, for example when a patient is on parole. They may add further stages to the risk escalator in order to postpone difficult decisions. Although demonstrably irrational in their own terms, such manoeuvres may be adopted *faut de mieux*.

Finally, the effectiveness of the RSU as an instrument of rehabilitation was predicated on the assumption of multiprofessional collaboration. Such collaboration cannot be taken for granted, but needs to be organisationally striven for. In particular, nursing occupies a central but difficult strategic

position with respect to offering a multi-dimensional, integrated approach to rehabilitation. Frontline nurses provide most everyday care, and have a potentially holistic view of patients unavailable to the other specialised professions. But lack a clearly defined rehabilitative role, at least in the minds of other professionals. Unless the involved professions respect and understand the roles of the others, risk escalators cannot work effectively. The difficulty of achieving such collaboration should not be underestimated.

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