

**THE CONSTRUCTIONS OF RISK BY MENTAL HEALTH
PROFESSIONALS WORKING IN A LOW AND MEDIUM SECURE
FORENSIC SERVICE**

ANNA WOODALL

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ABSTRACT

This study adopts a Foucauldian Discourse Analysis (FDA) on the subject of how mental health professionals working in low and medium secure forensic services construct the meaning of risk.

A critical review of the literature illustrates the emergence of the concept of risk and the diversity in which it is constructed including the proliferation of risk assessment tools in an attempt to quantify the phenomenon. In contrast, the aim of this study was to focus on the meaning of the concept by exploring how ten mental health professionals make sense of and construct risk while adopting an epistemological position of critical realism with social constructionism. Such an approach enabled an exploration of broader social and contextual factors influencing the constructed nature of the concept and the implications for their clinical practice.

Three interconnecting discursive sites were formed in the analysis of this research. These were termed: 'Constructing the system as an inhibitor to meaningful information about patients and risk', 'The construction of risk to professionals through surveillance and accountability' and 'The construction of risk in relation to responsibility and as something that can be transferred'.

Implications for clinical practice suggested by the analysis included the role of supervision and reflexivity, the short-term toleration of immediate risk by services, the role of forensic service policy in relation to the recovery agenda, and the suggestion of counter-inquiries alongside the current practice of homicide inquiries.

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CHAPTER ONE – INTRODUCTION

This study adopts a Foucauldian Discourse Analysis (FDA) on the subject of how mental health professionals working in low and medium secure forensic services construct the meaning of risk. In line with the approach, no preconceived hypotheses were used and instead an exploration of how ten mental health professionals constructed the meaning of risk in the context of an interview with me, a trainee clinical psychologist, was examined.

This thesis is presented in four chapters. The first chapter critically examines the literature on forensic risk assessment; the emergence of the concept of risk, and how the concept is constructed in varying ways throughout the literature. Chapter two outlines the methodology used in this thesis, chapter three presents the analysis and discussion of the research, and the final chapter provides a summary, a critical review of the research, and implications for further research and clinical practice.

1.1 STYLE AND TERMINOLOGY

I have written this thesis in the first person to assist in its readability and to make explicit that this research is itself a construction by me, the researcher, and does not claim to be an objective account which might be implied by the use of language in the third person.

To further ease readability, I have not repeatedly acknowledged through the use of quotation marks the problematic nature of terms such as ‘patient’, ‘mental illness’, ‘psychosis’ ‘mentally disordered’ and other related psychiatric labels that are acknowledged and debated elsewhere (Boyle, 2002, Rapley, Moncreif, & Dillon, 2011).

1.2 LITERATURE REVIEW

To review the literature for this study, I searched PsycINFO using EBSCO, an international online database resource. The literature on risk assessment in forensic mental health is vast and this examination was not intended to be a systematic review of the literature. I used a combination of the following search terms to collate a manageable amount of academic papers for examination:

- (clinical) or (psychology) or (clinical psychology) AND
- (forensic) or (forensic psychology) or (forensic psychiatry) AND
- (risk) or (risk assessment) AND
- (violence) AND
- (social constructionism) or (construction) or (social construct) AND
- (professional construction) or (professional account) or (professional opinion)

Searches specified peer reviewed journals and adult populations. An initial screen based on article titles and the abstract excluded articles not in English, those primarily focused on offender behaviour with no reference to forensic settings or populations, and articles with little focus on the assessment or discussion of risk.

I hand searched from the references of papers, taking particular notice of references that were repeatedly referred to in the literature. I searched Google using similar search terms which directed me to some useful articles and websites on the topic. I also signed up to receive updates from a blog on news and commentary pertaining to forensic psychology, criminology, and psychology-law by Karen Franklin, a forensic psychologist and adjunct professor at Alliant University in Northern California which directed me to useful academic developments in the area.

What follows is an examination of the literature as captured by the above search strategies, to provide a representation of the current academic landscape on this topic and to locate this research in that context.

The literature tells a story of the emergence of the concept of risk, namely risk of violence to others, in forensic mental health in reaction to the notion of 'dangerousness', the proliferation of research on potential factors associated with risk of violence and the development of risk assessment strategies (namely clinical, actuarial, and structured decision making tools). The literature is diverse in the way that risk is constructed and used. A large portion is focused on the academic and experimental pursuit of predicting risk, and development of risk assessment measures, while another sector of the literature is comprised of

academic reviews, reflections, and commentaries on the concept of risk and its development, the inherent uncertainties in the task of risk assessment for mental health professionals, and the ethical and practical implications of this on clinical practice.

1.2.1 A BRIEF HISTORICAL ACCOUNT OF THE EMERGENCE OF RISK AS A CONCEPT IN FORENSIC MENTAL HEALTH: FROM DANGEROUSNESS TO RISK

Provision of a brief account of how the concept and term risk came to be used in this setting will help situate the current psychological literature on forensic risk assessment. This section is intended to provide a brief account of key influences on the emergence of the concept and how risk has come to be constructed and used in the literature.

Beliefs about the cause of mental health problems have changed over time, however, the idea that mental disorder predisposes someone to acts of violence persists (Monahan, 2001). Despite educational campaigns to the contrary (Phelan, Link, Stueve, & Pescosolido, 2000) this belief seems to have intensified, as reflected in policies about those diagnosed with mental disorders and the public's expectation that mental health professionals should fulfil the role of ensuring public safety (Appelbaum, 1988). As a result, violence risk assessment has become an important part of routine practice by mental health professionals (Vogel, Robbe, Ruiters, & Bouman, 2011). The concept of 'dangerousness', up until the mid-1960s, arose only in relation to a minority of actual or potential patients or prisoners (Rose, 1998b). The debate about dangerousness recognised that while its diagnosis was difficult, drawing a distinction between those patients who were and were not dangerous was still considered a valuable exercise. Foucault suggests that there has been an ever increasing shift of focus in criminal proceedings whereby punishment has become more linked to individual motivation; *'from the crime to the criminal, from the act that was actually committed to the danger potentially inherent in the individual; from the modulated punishment of the guilty party to the absolute protection of others'* (Foucault, 2003a: 222). He argued that a knowledge-system able to measure the index of danger present in an individual that might establish the protection necessary in the face of such a danger made possible the idea that

crime should not just be the responsibility of judges but also of experts in psychiatry, criminology, and psychology (Foucault, 1978 in Rainbow & Rose, 1994).

The consequences of such an assessment of dangerousness included the detention of an individual and/or other means of loss of liberty and treatment and management recommendations. The significance of these consequences prompted prominent mental health professionals to question the continued use of assessments on issues of dangerousness given emerging evidence of their inaccuracy. Research in the 1970's suggested that assessments of dangerousness were inaccurate and unreliable (Cocozza & Steadman, 1976; Kozal, Bourcher, & Garofalo, 1972; Ennis & Litwack, 1974), so psychiatrists tended to over-estimate dangerousness and consequently people were detained with no firm legitimate basis (Steadman & Cocozza, 1974). The inaccuracy of clinical predictions was highlighted by Monahan (1981) who argued that psychiatrists and psychologists were no more accurate than in one out of three predictions of violence when assessing institutionalised populations with a history of violence and a mental health diagnosis.

Research as a result of a legal case, was considered by some as further evidence of professional inaccuracy. The legal case resulted in the mass transfer of patients from a New York maximum security hospital to civil hospitals and subsequently to the community on constitutional grounds in 1966 (*Baxstrom V Herold*, 323 U.S. 107). This enabled research on the transferred patients and conclusions were drawn that in the patients who had previously been assessed as mentally ill and dangerous by two psychiatrists, substantial over-predictions were made in the range of four to one (Steadman, 1973; 2000). Criticisms and concerns from leaders in the field were expressed about the scientific reliability of assessments of dangerousness particularly in an environment that favoured a preference for false positive errors meaning that people were preventatively detained who arguably would not go on to commit dangerous acts (Shah, 1978). Consequently the ethics of professionals engaging in such assessments were questioned. However, mental health professionals continued to be positioned as an expert and requirements to make assessments of dangerousness in the interest of public safety persisted.

The Tarasoff V Regents of the University of California case (1976) case and the court ruling of mental health professionals duty to protect is often cited as instrumental in positioning mental health professionals as having an explicit responsibility to public safety, whereby a requirement to warn others of potential harm from their patient was made explicit. The associated ethical dilemmas concerning confidentiality and the therapeutic value in the therapist and patient relationship as well as the practical implications of a legal imperative to report on something that is difficult to identify and define (how does one define an intention to act violently) has been debated (Fox, 2010). While not universally recognised the associated legal challenges on professional liability and fears of litigation arguably influenced 'defensive medicine' and has impacted on mental health professionals' acceptance of the premise of 'duty to protect' and their role in ensuring public safety (Yufik, 2005). In the United States, the ruling in the landmark case Barefoot V Estelle (1983) that despite evidence of professional inaccuracy in assessments of dangerousness, mental health professionals were not 'incompetent to predict with an acceptable degree of reliability that a particular criminal will commit other crimes in the future, and so represent a danger to the community', made the relevance of professional opinion in dangerousness assessments well established (Parsi, Wachsmuth, Packman, & 2009).

Similarly in the United Kingdom, mental health professionals' role in safeguarding public safety has been assured. This is highlighted by government recommendations to psychiatrists to explicitly consider the potential for patients to engage in dangerous behaviour if discharged (NHS Executive, 1994) and the implementation of homicide inquiries despite evidence that homicides by people considered to be mentally ill have not increased (Taylor & Gunn, 1999). Instead, people with mental illness are far more likely to be the victim of homicide or die as a result of suicide (Hiroeh, Appleby, Mortensen, & Dunn, 2001). Public inquiries of violent acts perpetrated by psychiatric patients have highlighted the potential adverse consequences and publicity associated with a single false negative assessment of someone's potential for dangerous acts. These inquiries focus on decision making by individual clinicians leading to demands on clinicians to be rigorous and methodical in their decisions about patients deemed to be a

potential risk to others (Snowden, 1997). The inquiries of most significance highlighting provisions for after care in the community include the killing of Mr Jonathan Zito by Christopher Clunis in 1992 and the inquiry into the killing of a social worker, Isabel Schwarz, by a patient, Sharon Campbell in 1984. The inquiries were influential in the introduction of obligatory care planning for people requiring secondary mental health Care (Care Programme Approach). Other changes in service delivery included the introduction of supervision registers, conditional discharge from hospital and compulsory inquiries into serious incidents (Chiswick, 1995).

Such a climate of inquiry and the personal and public consequences of perceived failure of care and the identification of a dangerous person have given an impetus to the expanding work to improve assessment procedures and a '*sea change...away from assessing dangerousness to assessing (and managing) risk*' (Duggan, 1997). This challenge is particularly relevant in forensic services that are tasked with managing the care of offenders who have been identified as having a mental illness. A concept analysis of '*forensic risk*' (Kettles, 2004) suggests that the term has moved quickly from the idea of dangerousness to a concept that has many related parts with a whole literature base of its own including policy, management, risk assessment approaches, risk assessment instruments, and security as linked to levels of risk.

The implication of mental health professionals' requirement to fulfil an assessment role when there was a suggestion of their inaccuracy prompted a reconceptualization of the task. An alternative approach to assessing future violence was argued, that it should be framed in a probabilistic manner and be defined in terms of risk not dangerousness (Steadman & Monahan, 1993). Risk, a term borrowed from the insurance industry, is perhaps more conducive to a more objective and scientific approach to prediction of adverse events (Snowden, 1997). A demand for evidence based, structured, and transparent decision making was met by a surge in academic activity to improve risk assessment through experimental means. This has involved using statistical approaches that are argued to be more objective (Monahan, 2005) than the subjective judgements of mental health professionals. This aspect of the literature will be examined in the following section.

1.2.2 ACADEMIC AND EXPERIMENTAL PURSUIT TO ACCURATELY ASSESS AND MEASURE RISK OF VIOLENCE

The following section will critically examine the area of the literature that is concerned with the academic pursuit of accurately assessing and measuring risk of violence. In section 1.2.3 I will go on to examine the conceptual issues surrounding risk in the literature to further reiterate the diversity in how the concept of risk is being constructed and used.

1.2.2.1 Proliferation of studies on risk assessment tools

Studies based on large cohorts of patients and/or offenders released from institutions and followed into the community in an effort to ascertain the factors that might predict future violence were instrumental in the development of risk assessment tools that the literature largely defines as either employing an actuarial or a structured professional judgement (SPJ) approach.

Actuarial tools involve scoring individuals on particular weighted factors that in prior research have been associated with the particular future adverse outcome of interest. Individual's scores are algorithmically cross-referenced with tables in the tool's manual to produce a probabilistic estimate of their risk. Examples in the literature include Violence Risk Assessment Guide (VRAG) (Quinsey, Harris, Rice, & Cormier, 1998), Sexual Offender Risk Assessment Guide (SORAG) (Quinsey, Harris, Rice, & Cormier, 2006), Static-99 (Hanson & Thornton, 1999; Harris, Phenix, Hanson, & Thornton, 2003), Level of Service Inventory – Revised (LSI-R), (Andrews & Bonta, 1995), Medium Security Recidivism Assessment Guide (MSRAG) (Hickey, Yang, & Coid, 2009), Iterative Classification Tree (ICT) (Monahan et al., 2005), and the Psychopathy Checklist – Revised, which is not a specific risk assessment tool but is often used as such given its association with risk of violence (PCL-R) (Hare, 1991; 2003).

SPJ tools generally involve administrators to record the presence or absence of a factor, derived from theoretical, clinical and/or empirical support, in relation to a particular individual. The tools aid in the development of a risk formulation and include classifying the individual into a risk category of low, medium, or high. The Department of Health (2007) recommends that services adopt a framework such as this. Rather than just predicting violence, the SPJ approach aims to guide

intervention to minimise future violence (Vogel et. el., 2011). Examples in the literature include Historical Clinical Risk Management-20 (HCR-20) (Webster, Douglas, Eaves, & Hart, 1997) Structured Assessment of Protective Factors for violence risk, (SAPROF) (de Vogel, et al., 2011), Short-Term Assessment of Risk and Treatability (START) (Webster, Martin, Brink, Nicholls, & Middleton, 2004), Spousal Assault Risk Assessment (SARA) (Kropp, Hart, Webster, & Eaves, 1995; 1999), Sexual Violence Risk-20 (SVR-20) (Boer, Hart, Kroop, & Webster, 1997), Dynamic Appraisal of Situational Aggression – Inpatient Version (DASA-IV) (Ogloff & Daffern, 2006), Violence Risk Scale Version 2 (VRS-2) (Wong & Gordon, 2000), Clinical Inventory of Dynamic Reoffending Risk Indicators (CIDRRI) (Philipse, Koeter, Van Der Staak, & Van Den Brink, 2005). In forensic units in the United Kingdom Kettles et al. (2001; 2003) found that there were 57 different named forensic risk assessments in use.

The above is not intended to be an exhaustive list nonetheless it illustrates the burgeoning of risk assessment tools of all kinds for varying purposes (such as risk of violence, risk of sexual violence, risk of violence in the community or in an institutional setting). The literature includes numerous studies that claim to test and demonstrate the validity of such measures; to demonstrate that the risk categories delineated correspond to future rates of offending or violence. In these studies risk is something to be conceptualised in a probabilistic term, a measure of likelihood that someone will engage in some future behaviour e.g. *‘Of the 102 patients who were classified by the software as low risk, 93 (91%) had no reported violent acts, and nine (9%) had at least one reported violent act. Of the patients classified by the software as high risk, 36 (65%) had no reported violent acts, and 19 (35%) had at least one reported violent act’* (Monahan et al., 2005). No tool claims to have 100 percent accuracy and as such these exercises result in predictions inevitably falling into categories of true positives, false positives, false negatives, and true negatives. The literature is full of studies that through repeated testing across different populations, using different aspects of particular tools, and using varying timeframes of predicted violent behaviour or offending are engaged in an effort to determine whether they can locate patients’ behaviour within a framework of probabilities that seeks to minimise the false negatives and false positives. An analysis, Receiver Operating Characteristics (ROC), is often

quoted in the literature as a statistical way to measure this (Mossman, 1994) despite some authors questioning its clinical utility (Szmukler, Everitt, & Leese, 2011). An ROC plots the trade-off between true positives and false positives across a test's measurement range, graphically depicting the trade-off in specificity that occurs as sensitivity is increased. The area under the curve (AUC) is the effect size estimate ranges from 0.0 (perfect negative prediction) and 1.0 (perfect positive prediction).

In an effort to assess the predictive utility of a particular tool, it is repeatedly used in different populations and across different contexts. The literature includes numerous such studies like the HCR-20 and its sub-scales being assessed in various studies (Gray, Taylor, & Snowden, 2008; Ho, Thomson, & Darjee, 2009; Arbach-Luioni, Andres-Pueyo, Pomarol-Clotet, & Gomar-Sones, 2011; Strand & Belfrage, 2001; Dernevik, 1998; Grevatt, Thomas-Peter, & Hughes, 2004, Gray et al., 2003, Douglas, Ogloff, & Hart, 2003) including on female patients (Schaap, Lammers, & de Vogel, 2009), in foreign samples e.g. a Dutch version (de Vogel & de Ruiter, 2006), and ethnic minorities (Snowden, Gray, & Taylor, 2010). In these types of studies risk is conceptualised as future violence as related to risk categories set out by the tool itself and attempts are made to generalise these probabilistic terms to the population of people in the study. From a social constructionist perspective, this production of risk assessment tools and the associated strategies and institutional practices, rather than simply an effort towards an ever increasing and truer understanding of risk, it has actually had a productive effect; producing '*truths*' on the concept of risk that then warrant certain actions. Through these information collecting and analytical efforts '*risk*' becomes problematized; something that is identified and rendered calculable and therefore governable (Lupton, 1999).

The following studies illustrate the way in which risk is constructed whereby an individual is labelled '*at risk*' or '*more at risk*'; located within a network of factors which is drawn from the observation of others to render them more or less likely to engage in undesirable behaviour:

Macperson and Kevan (2004) did an assessment of the predictive validity of a subscale (Clinical Scale) of the HCR-20 for inpatient violence during an

admission process; analyses on whether increased scores on a particular scale relate to a patient's involvement in violence in hospital. One of the study's principal findings illustrates how risk was constructed in probabilistic terms in this context, *'physical violence was over four times as likely in the patients scoring above the 75th percentile on the C (clinical scale) scale than those scoring below'* (Macperson & Kevan, 2004). Here the conceptual shift from dangerousness to risk is illustrated whereby patients are not individually labelled as potentially dangerous but rather the potential for danger (risk) is constructed within the level of a population or group. So while the danger is not located within an individual, the practice of categorising a patient as e.g. *'above the 75th percentile'* warrants certain practices to be enacted on the individual e.g. types of institutional containment and security.

Similarly a study aiming to examine the validity of risk assessment tools (HCR-20, VRAG, PCL-SV) to predict violence following discharge from a Scottish medium secure unit is illustrative of how risk of violence is constructed in probabilistic terms in some of its findings *'the risk assessment tools were found to have moderate accuracy in predicting serious violent incidents, and marginal to moderate accuracy in predicting minor violent incidents. The VRAG appeared to perform best for predicting any violence, but the H-10 appeared as good as the VRAG for predicting serious violence'* (Ho, Thomson, & Darjee, 2009).

As is common in psychological research on questionnaires and tool development, in order to demonstrate the validity of a particular tool, a measure of construct validity is sought; determining how much it correlates with another tool that in the academic literature is considered reasonably valid. In this case the VRS-2 was assessed against the HCR-20 in a group of male inpatients in an English medium secure forensic service. Again risk is constructed in probabilistic terms with the use of statistical analysis to determine how well each measure discriminated between violent and non-violent subgroups; *'the predictive validity of these two measures for violence (i.e., a recorded incident of assault on another person) at 12 months post admission was examined using receiver operator characteristics (ROC) analyses'*. Again, data drawn from a population or a group to produce a measure deemed valid is able to be used to classify individual's risk and warrant certain practices.

A range of interpretations on the clinical usefulness of such risk assessment tools exist in the literature from the developers of the HCR-20 carefully describing their instrument as a research tool (Norko, 2000) to the authors of the Violence Risk Appraisal Guide (VRAG) arguing at one stage for the complete replacement of clinical assessments of dangerousness and risk with actuarial approaches (Quinsey, Harris, Rice, & Cormier, 1998), to more sceptical voices on the actuarial pursuit of risk assessment (Litwick, 2001).

1.2.3 CONCEPTUAL ISSUES AND PROFESSIONAL DISCORD

The following section will highlight the dilemmas and conceptual difficulties regularly cited in the literature. I will examine them in relation to the tension that exists between actuarial and structured clinical judgement approaches and the notions of risk prediction and risk management.

1.2.3.1 Actuarial and Structured Clinical Judgement Approaches

The increase of actuarial strategies and tools gave rise to inevitable debate and comparison of such strategies with what is generally referred to in the literature as 'clinical judgement'. Clinical judgement is considered to be a prediction of future behaviour of an individual based on clinical experience and professional training. Running in parallel to the pursuit of the predictive utility of risk assessment tools, numerous studies have tried to compare the utility of actuarial instruments with clinical judgement in effort to re-examine the notion that clinical judgement will always be superseded by more objective probabilistic assessment of risk (Lidz, Mulvey, & Gardner, 1993). A study by Smee and Bowers (2008) is one such example that argued the merits of clinical judgement. They determined that masters psychology students using the VRAG underperformed in comparison to practicing psychologists and psychiatrists in predicting violence using 10 narratives from the MacArthur Violence Risk Assessment Study (Monahan et al., 2001).

Risk of future violence can and is constructed in varying ways in the literature. Of interest to a clinician is not just the likelihood of an adverse event but the nature of it; how imminent an act is, how severe it is, and how frequent is the likelihood of such a risk of future violence. Actuarial variables or tools that endeavour to provide a dichotomous definition of criminal recidivism do not attend to such

things and consequently some comparisons and judgements of the value of actuarial and clinical approaches are misleading and confused as they often have a different focus. Sjostedt and Grann (2002) attempted to remedy this by drawing comparisons on similar outcome measures. They examined a five-year cohort of adult men released from prison for sexual offending in Sweden and attempted to apply actuarial methods (RRASOR; Hanson, 1997 and Static-99; Hanson & Thornton, 1999) to the prediction of clinically relevant variables such as specifically defined *'imminence, frequency, nature, and severity'* of sexual reoffending using ROC analysis. The authors argued that the actuarial methods were useful in predicting who would and would not reoffend however they were less useful in predicting the types of reoffending behaviours that most concerned clinicians; repeated injurious sexual violence.

The value of clinical judgement was argued in a study on professional members of a multidisciplinary team in an English forensic service. Risk was constructed as *'not just the assessment of violence or criminogenic risk in the long term; but, rather, a diversity of risk criteria over the short to medium term including behaviour harmful to self, to others and property, psychiatric relapse, and risk to the public at large'* (Fuller & Cowan, 1999: 278). The authors argued that actuarial tools have a restricted focus of a single risk of violence criterion which is not appropriate for the diverse demands of forensic services. Furthermore, while actuarial tools highlight certain factors that might increase or decrease risk, their usefulness might be undermined by the population a clinician is working with e.g. being a woman might reduce an individual's associated risk on an actuarial instrument however if you are working with violent women, this is likely to give you an underestimation of risk as the comparison is made with the general population. Consequently, this can be misleading and seriously under estimate risks of future violence or offending.

The predictive accuracy of professional's judgements of future incidents was measured across certain risk categories. An ROC analysis was employed and accuracy was assessed as significantly better than chance in some risk categories (risk to staff, risk to patients) however categories with low base rates (occurrence of such an event is low e.g. risk of self harm, risk to public) yielded predictions of no value. The authors contended that despite the advance of

actuarial approaches, multi-disciplinary clinical judgement '*can achieve prediction accuracy substantially in excess of chance levels for several types of short to medium term risks encountered in inpatient forensic settings*', (Fuller & Cowan, 1999:286) suggesting that it is perhaps more sensitive and flexible to a local context, a common criticism of actuarial approaches, however it did caution against substituting actuarial methods completely for clinical judgement.

The limitation and problems associated with the application of tools that are developed from large cohorts and then applied to individuals in clinical settings are regularly cited in the literature (Nilsson, Munthe, Gustavson, Forsman, & Anckarsater, 2009; Hart, 2007). Points raised are often in relation to the group norm being too dissimilar to the individual you are assessing leading to poor classifications and predictions of recidivism (Sreenivasan Weinberger, Frances, & Cusworth-Walker, 2010), the outcome of the tool not being in line with the outcome the clinician is focused on e.g. type of violence rather than risk of violence in general (predictions of antisocial behaviour involving violence will be more accurate due to higher base rates than violent offences) regularly referred to as the '*base rate*' problem (Ryan, Nielssen, Paton, & Large, 2010; Szmukler & Rose, 2013), and the timeframe used in the tool's development of the outcome may not be in line with the timeframe that clinicians need to focus on. The difficulties associated with applying risk assessment tools to clinical work are taken up and used in different ways to promote different agendas within the literature.

Hickey (2009) makes sense of the highlighted difficulties and argues that despite these limitations the PCL-R and the VRAG are potentially suitable for mentally disordered offenders in the UK. However the proliferation and development of more tools is made possible by highlighting a need for it by emphasizing that those current tools are developed '*in different jurisdictions on samples with different characteristics*' (Hickey, Yang, & Coid, 2009,:202). A claim made by these authors to develop the MSRAG using an English medium secure population of patients with high rates of a diagnosis of schizophrenia (Hickey, Yang, & Coid, 2009). Hickey (2009) advocates more large scale outcome studies in this population and refers to an actuarial risk prediction measure currently being developed following a large scale retrospective outcome study on British

mentally disordered offenders discharged from medium secure services (Hickey & Coid, in preparation).

Whereas elsewhere it is argued that the pursuit of risk assessment in forensic mental health is not about prediction but classification *'Psychiatric clinicians conducting 'risk assessments' might feel, intuitively, that they are trying to predict whether or not the patient in front of them will come to or cause some harm, but this interpretation is wrong. The clinicians are actually categorising patients according to results of earlier research'* (Ryan, Nielssen, & Large, 2010:339).

This classification has implications for service provision and resource allocation in relation to an individual. The interventionist aspect of clinicians is often inadequately or unable to be accounted for in risk assessment tools; they are confounded by an unknown amount of false positives because of intervention services and professionals who are required to proactively reduce untoward incidents.

The classification of individuals into a risk category is an approach that is reflected in the structure of forensic services in NHS England whereby services are categorised as high, medium, or low security. As detailed in commissioning guidance for forensic services; *'each of these levels of service provision reflects the different levels of risk that patients are considered to present to others. Consequently, each level provides a range of physical, procedural and relational security measures to ensure effective treatment and care whilst providing for the safety of the individual and others'* (Joint Commissioning Panel for Mental Health, 2013 P. 7). This is a development that some authors claim is a problematic way of allocating resources and making decision about care (Ryan, Nielssen, & Large, 2010).

It should be noted that in light of the proliferation of risk assessment tools, a question of authorship bias has been raised whereby *'studies authored by tool designers reported predictive validity findings around two times higher those of investigations reported by independent authors'* and *'none of the 25 studies where tool designers or translators were also study authors published a conflict of interest statement to that effect'* (Sing, Grann, & Fazel, 2013) raising questions

about the other potential agendas in the development of tools so often represented as 'objective'.

1.2.3.2 Risk Prediction or Risk Management

Another conceptual issue in the way risk is constructed in the literature is the contention that clinical judgement and actuarial approaches are not as theoretically distinct as some of the literature suggests (Ward & Eccleston, 2000). Actuarial variables are sometimes defined as static variables, historical variables that are unchanging and clinical variables are considered as more dynamic factors that can change. An actuarial variable might also be considered as a factor that can be measured with little human judgement required e.g. age or offence data. However other variables in actuarial tools that might eventually be reduced to a number require clinical acumen to assess e.g. Psychopathy as measured by the Psychopathy Checklist Revised (PCL-R; Hare, 1991) requires clinical judgement to complete. As a consequence authors in a lot of instances have tried to move away from the actuarial vs clinical judgement debate and instead other conceptual issues with regards to risk assessment have been raised namely that of risk prediction and risk management.

Actuarial risk assessments primary aim is the prediction and assessment of the likelihood of an adverse event. This does not translate to the clinical task of management and prevention of criminality, which is a much more proactive interventionist approach rather than a passive attempt at prediction. The aim and purpose of an assessment; prediction or management, is important and should be made explicit to avoid conceptual misinterpretation and confusion (Heilbrun, 1997). The ever increasing pursuit of a risk assessment tool that provides the most predictive utility is argued by some to be the wrong endeavour. The predictive accuracy of the PCL-R, LSI-R, VRAG, and the General Statistical Information on Recidivism were compared to four instruments randomly generated from a pool of original items found in these tools. None of the four original instruments better predicted post-release failure than the four randomly generated instruments. The authors suggested that the instruments are only measuring criminal risk, and no single instrument captured sufficient risk assessment information to result in better prediction than the randomly derived instruments (Kroner, Mills, & Reddon, 2005). Skeem and Monahan (2011)

suggested that the risk assessment field might be reaching a '*point of diminishing returns in instrument development*' (P.41). If risk assessment measures vary little from one another and they account for little of the overall variance in predictive accuracy a shift from predicting violence to trying to understand its causes and prevent its occurrence; risk management, is argued to be a more fruitful approach.

Much of the literature suggests that factors associated with the most predictive utility are static and historical variables including age at first arrest, gender (male), low socioeconomic status, offence history, past substance misuse (Hilday, 1995; Norko, 2000; Ward & Eccleston, 2000) and that the contribution of mental illness is low (Walsh & Fahy, 2002). Authors have been calling for more research on what is defined as dynamic factors, factors that can be changed and potentially reduce the likelihood of future violence which is more in line with a focus on risk management rather than prediction. Douglas and Skeem (2005) outline a '*review of promising dynamic risk factors*' including impulsiveness, negative affect, psychosis, antisocial attitudes, interpersonal relationships, treatment adherence and alliance and advocated further research on theory development to aid clinical practice. More recent developments on measuring dynamic factors in assessments have been seen in tools such as the SAPROF (de Vogel, de Vries, de Ruiter, & Bouman, 2011) which was designed according to the SPJ approach with the intention of being used alongside the HCR-20 or SVR-20. It includes what the authors describe as protective factors e.g. leisure activities, motivation for treatment, life goals and is arguably more in line with a developing approach in forensic populations; the good lives model, (Barnao, Robertson, & Ward, 2010) and the recovery agenda (Drennan & Alred, 2012).

It is argued that the inherent complexity in assessments of future violence is inevitably reduced by a risk assessment tool. Norko (2000) suggested that such tools and techniques '*are traps; they will always oversimplify the situation and lead to a false state of security*' (P. 286) and Munro argued (2000) in his examination of public inquiries into homicides by people with mental illness, that improved risk assessment played a limited role in reducing homicides and that improved psychiatric care to reduce relapse was identified as the key factor in preventing violence.

These ongoing concerns and dilemmas in the literature highlight the continual tension imposed on a clinician working in forensic mental health; to take up the role of a clinician and focus on clinical activity to reduce distress, and the pull to take up the position of a state actor in public protection and provide decisions deemed adequate and defensible by external bodies (Carrol, Lyall, & Forrester, 2004).

1.2.4 RISK ASSESSMENT PROCESSES

While the literature is largely focused on risk factors and risk assessment tools, clinicians have to engage with patients in a risk assessment process which may include the use of tools and instruments, however clinical interviewing is perhaps far more nuanced and complex than simply administering questionnaires. The aim of risk assessments can be considered to be twofold; to identify those likely to engage in future violent behaviour and to identify factors that can be addressed to minimise future risk through intervention and/or management strategies (Moran, Sweda, Fragala, & Sasscer-Burgos, 2001).

The collation of information is important in the process of risk assessment, from which a clinician will try to ascertain the likely severity and frequency of future adverse events (Snowden, 1997). A variety of sources is advocated including third party information and the clinician's task is to compile relevant historical information e.g. previous acts of violence, cultural background of violence, social instability, substance misuse, poor compliance with treatment and identify any precipitating factors or triggers to changes in mental state before periods of illness and/or violence (Thompson, 1999). Constructing a formulation of past behaviour to inform intervention strategies is ideally individually tailored (Lewis and Doyle, 2009) and is something that is encouraged and endorsed by NHS guidance in *Best Practice in Managing Risk* (Department of Health, 2007).

Formulation is defined as identifying and describing '*predisposing, precipitating, perpetuating, and protective factors and also how those interact to produce risk*' (Department of Health, 2007:17). This is perhaps a shift away from just identifying risk factors to trying to conceptualise and understand how such factors interact to produce violent perpetration in an individual, consequently a risk formulation should inform interventions that comprise a risk management plan. SPJ tools such as the HCR-20 have been designed to be used in a clinical

setting alongside ideas of individual formulation and the development of risk management plans (Samuels, O'Driscoll, & Basaley, 2005) which are regularly reassessed (Ward & Eccleston, 2000) in a multidisciplinary context and in some instances with the patient.

The inherent uncertainty in risk assessment is argued by some to be minimised by critically evaluating the information used to base decisions and the adoption of a broad-based approach to treatment whereby active symptoms of illness are not the only focus. In a forensic context, hospitalization can enable clinicians to continually observe patients and gather longitudinal knowledge about them to understand their offending and response to interventions across varying situations in a graded discharge process e.g. escorted leave, unescorted leave (Carrol, Lyall, & Forrester, 2004).

A move towards formulation based practice can be seen as a way to communicate about an individual's risk that is beyond a simple descriptive, predictive and, categorical (e.g. low, medium, or, high) manner, to a more complex explanatory approach that attempts to establish not just if there is a risk, but what comprises it and what situations might it be expressed in. However, such complex processes in assessment are difficult to define and conceptualise and is perhaps indicative of their limited representation in the academic literature. Questions about the efficacy of such an approach still abound including what constitutes an adequate formulation, how does it translate into a treatment plan, how can it be evaluated, and is there a point where the complexity of a formulation undermines its clinical utility (Lewis & Doyle, 2009).

1.2.5 RESEARCH ON PROFESSIONAL PRACTICE

In light of the wealth of information on risk assessment and the often contradictory views on its usefulness, it is interesting to review some of the research on clinical practice, to determine how professionals make sense of the academic backdrop to their clinical work. Research ranged from clinician's views on risk assessment tools, how they incorporated actuarial information into assessments, and how other variables like professional confidence, and other clinician biases might influence the assessment of risk.

The usage and perceived usefulness of particular risk assessment tools by staff in English medium secure forensic services was surveyed and it was determined that *'most medium secure units use structured assessments and staff view them positively'*. The HCR-20 and PCL-R were considered the most widely used, prompting the authors to encourage other services to consider them as their first choice (Khiroya, Weaver, & Maden, 2009). This is in contrast to an attitudes survey on generic risk assessment tools by the Royal College of Psychiatrists (2007) in which 50 percent agreed that the *'use of a risk assessment form by a good clinician results in better decision making'* and 60 percent of the 1937 respondents agreed that the *'prime purpose of completing a form is defensive, i.e. to protect the organisation'* (Szmukler & Rose, 2013).

Analysis of a subgroup of risk assessments in which actuarial information was in disagreement with the clinical decision about an individual determined the existence of what the author defined as a *'precautionary principle'* (Ansbro, 2010) whereby professionals were more likely to override actuarial information that indicated low rather than high risk. An examination of professionals' level of confidence in their assessments using the START concluded that higher confidence was actually associated with lower predictive accuracy, a finding that the authors cited as a rationale for professionals to receive feedback on predictive validity and for ongoing training in risk assessment (Desmariais, Nicholls, Read, & Brink, 2010). Such a finding on the influence of confidence was dissimilar to a study that suggested levels of confidence improved accuracy in both actuarial judgements (HCR-20 total scores) and structured professional judgements (of low, medium, and high risk) (Douglas & Ogloff, 2003), further illustrating that despite efforts to quantify something that is related to the process of risk assessment, outcomes are still varied.

There is research to suggest that biases in relation to gender and race result in an over-estimation of risk in men and non-white individuals and an under-estimation of risk in women, (McNiel & Binder, 1995) and that clinicians might be subject to the *'halo effect'* whereby the more dissimilar you are to a person, the more likely you are to attribute negative aspects and risk factors as intrinsic to that person (O'Rourke & Hammond, 2007). Davison (1997) highlighted practical barriers that might influence a professional's risk assessment including busy and

stressful work situations with many pressures, lack of time and resources, and the importance of counter-transference which can engender strong feelings in clinicians (Glaser, 1996). There is an increasing trend for risk assessment to be seen as a multi-disciplinary task rather than falling into the remit of one professional group (Lewis & Webster, 2004) a development that some authors suggest may minimise some of the biases described above (Carroll, Lyall, & Forrester, 2004).

1.2.5.1 Qualitative Research

Perhaps indicative of the academic literature's pursuit to quantify risk, there is a paucity of qualitative research on professional accounts or conceptualisations of risk in forensic mental health services. A qualitative study examining the process in multidisciplinary ward rounds of granting leave for patients, interestingly found that risk per se was seldom discussed in explicit terms. The authors suggested that this might be explained by the limits on these conversations which are constrained by the volume of information and the time pressures of clinical work, which might mask the extent of implicit clinical knowledge held by the team, a hypothesis that they suggested required further investigation. The lack of explicit links to risk was raised as a '*political risk*' in a cultural context that calls for transparent clinical decision making, something the authors suggested is perhaps an impossibility and can only be considered as the '*holy grail*' (Lyall & Bartlet, 2010).

The constructions of risk in a discursive analysis of accounts given by patients and professionals following conditional discharge from forensic mental health services were drawn from 59 interviews. The author contended that professionals and conditionally discharged patients had distinct views about risk in community living which were driven by contrasting values and priorities. Of particular interest was the tension in how professionals and service users constructed continual surveillance as part of conditional discharge. Professionals constructed the freedoms offered by conditional discharge as restricted for the sake of public safety. They were aware of their accountability and were attuned to the risk of service users causing harm, the probability of which they assessed as high due to a patient's previous history. Patients did not consider themselves likely to re-offend and instead were more concerned with community rejection as a result of

being continually publically monitored. The author concluded that professionals continually prioritised public protection as the dominant focus of their work and patients interpreted the prolonged surveillance as contributing to discrimination and stigma which consequently increased their isolation and rejection from the communities that they were trying to integrate back into (Coffey, 2012).

1.2.6 SUMMARY AND RATIONALE FOR CURRENT STUDY

The literature on risk and risk assessment in forensic mental health is vast and diverse in its content. There has been a drive in the field to try and assess, predict, and measure the risk of violence or reoffending through the development and repeated testing of various risk assessment tools. This pursuit is questioned by some and researchers continue to grapple with conceptual dilemmas and on how to usefully apply experimental research to the complexity of clinical practice in this area, given the inherent tensions faced by professionals in a medico-legal context.

In order to understand how mental health professionals make sense of the diversity, tension, and ongoing controversy that is the academic backdrop of their work, this study proposes a different approach than previous research. Despite the increasing dominance of risk practices in the work of forensic mental health professionals with their patients there is little research that asks professionals their views in a format that is flexible and can accommodate the impact of the broader socio-cultural context within which they work.

This thesis adopts a social constructionist perspective (discussed in detail in section 2.1.3) which considers the way in which phenomena are constructed as having a material difference to the nature of that phenomena. In respect to this study, the way in which mental health professionals make sense of and construct risk has a direct impact on their clinical practice with patients.

By utilising qualitative methods and the approach of Foucauldian Discourse Analysis (FDA) (discussed in detail in the following chapter) this study hopes to provide an additional perspective for analysing and understanding the construction of risk and practice of mental health professionals. It is anticipated that a shift away from a realist epistemological position will open up an examination of the social and cultural practices that render certain practices

problematic. People are not inherently '*low*', '*medium*' or '*high*' risk rather their behaviour when compared to others is seen as different and constructed as such. As a consequence people should not be labelled and diagnosed in an uncritical way. A social constructionist approach can be used to map the discursive practices and power structures to examine how certain behaviours and people are constructed as risky. It is important to understand how such constructions are made and what ways of conceptualising risk are possible within a mental health professionals' particular social, professional and political context.

1.2.7 RESEARCH QUESTIONS

As such this study started with a broad research question:

- How do mental health professionals working in a low and medium secure forensic service construct the meaning of risk?

Throughout the research process the following research sub-questions were used to analyse the data:

- What is being constructed as risk and what is being problematized?
- What technologies of power and self are being deployed in these constructions?
- What subject positions and social practices are made possible from these constructions?

A detailed discussion of the methodology will follow in the next chapter.

CHAPTER TWO - METHODOLOGY

This chapter provides an outline of the epistemological position and methodological approach adopted in the study. A detailed description of the method used, including participant recruitment and profile, data collection, transcription and the approach to analysis is outlined.

2.1 PURPOSE OF THE RESERARCH

The aim of this research was to examine how risk is constructed by mental health professionals, how particular constructions are made and rendered problematic, and the implications of these constructions on clinical practice. The focus of the study was an exploration of professionals' talk rather than an attempt to measure, compare, or predict quantifiable variables. As a consequence a qualitative method has been used as this facilitates an exploratory approach to the data (Harper, 2012). Given the analytical focus is not only on what professionals say and describe but also on *how* they use language to construct risk and what discourses are available to them to draw on in the context of their work, a FDA was considered most appropriate. A further explanation and rationale for this type of analysis is presented below.

2.2 EPISTEMOLOGY

The analytical approach and method employed in a piece of research is underpinned by particular philosophical assumptions and principles. Following Willig (2001) I understand epistemology to be concerned with the nature and scope of knowledge, what knowledge is and how it can be acquired and the extent to which any knowledge or subject can be known. The epistemological position I, as a researcher, adopted is, critical realism with social constructionism, which will be described in detail below. This framework informed the approach I took when engaging with the academic material in the area of risk in forensic mental health, my method of data collection, and my analysis of the data. The combination of critical realism and social constructionism could be described as ontologically realist in terms of acknowledging some kind of independent existing reality but epistemologically relativist in asserting that we can never be in direct

contact with it given the constructed nature of knowledge in social processes (Harper, 2011).

2.2.1 Social Constructionism

Following Burr (2003) I understood social constructionism to be critical of taken for granted notions that are often communicated as objective or as facts, this is due to a belief that concepts are culturally and contextually bound. Such knowledge and concepts of what constitutes a '*truth*' in a particular context are constantly shifting because our understanding of the world is made possible through social processes; our interactions with people rather than any kind of direct contact with the nature of reality. Furthermore, these constructions are not seen as representing the world but as being instrumental in creating versions of how the world is experienced and therefore invites different possible actions for people, meaning that the creation of knowledge and social action are intricately linked.

The problem associated with taking a positivist approach to understanding risk is that risk becomes embodied and viewed as an object or knowledge that exists independently of context and is thus located in an individual. As such, I as a social constructionist researcher was concerned with the constructed nature of social reality and I aimed to trace the ways in which the phenomenon of risk was constructed through language and reflected upon the consequences for those who were '*positioned*' and '*subjectified*' by these social constructions (Harper, 2012). In relation to my research topic of risk I took an anti-essentialism approach whereby references to risk were not conceptualised as something that could be inherent to a particular thing or person. Risk language was understood to be historically and culturally situated, and as a form of social action with a performative role rather than a passive description of the world. I did not focus on individual people as possessors of knowledge with cognitions and thoughts about risk, instead I attended to social interaction and social processes as a way to understand the phenomena of risk.

2.2.2 Critical Realism

My understanding and application of critical realism, is that while it acknowledges how knowledge and culturally situated '*truths*' are constructed through language

and process, it also places value on looking beyond language to take into account social and material realities.

Critical realism affirms physical reality, both environmental and biological as a legitimate form of enquiry but recognises that its representations are characterised and mediated by language, culture, and political interests rooted in for instance race, class, gender, and social status (Bhaskar 1989). It points to the undeniable reality of social contexts, institutions and of power relations within which any discourse takes place (Parker, 1992). As a critical realist I therefore argued that it was necessary to go beyond the language and text being analysed to draw on other evidence to support the claims being made. Following Willig (2001) who argued for an acknowledgement of social and material realities in structuring our actions, and imposing constraints on the things we might do and say, I as a researcher taking a critical realist position aimed to add a further level of interpretation by going beyond the text and to see what was said in a broader social, historical and cultural context.

2.3 FOUCAULDIAN DISCOURSE ANALYSIS

Discourse analysis informed by Foucauldian principles is focused on the productive quality of language; the implications for possible ways of being that are structured by culture, and the local availability of dominant discourses (Willig, 2001). FDA methods have been used to analyse text from a range of sources, including interviews. It aims to illustrate how power, by creating knowledge within a certain discourse, produces the subject and its associated discursive objects and practices (Brown & Locke, 2008).

Discourses, while difficult to define given a post-structuralist view of knowledge, can be understood as a '*bounded body of knowledge and associated practices, a particular identifiable way of giving meaning to reality via words or imagery*' (Lupton, 1999:15). Discourses enable people to understand and perceive the social, cultural, and material world and they can both '*delimit and make possible what can be said and done about phenomena such as risk*' (Lupton, 1999:15).

A key Foucauldian concept relevant to an analysis such as this is his understanding of knowledge/power as an inextricable concept, in that they directly imply one another.

Perhaps, too, we should abandon a whole tradition that allows us to imagine that knowledge can exist only where the power relations are suspended and that knowledge can develop only outside its injunctions, its demands and its interests...We should admit rather that power produces knowledge (and not simply be encouraging it because it serves power or by applying it because it is useful); that power and knowledge directly imply one another; there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations (Foucault, 1977:27).

From this conceptualisation of knowledge/ power the site of language as a production of knowledge/power is warranted because to define the world or a person in a particular way also allows the practice of certain acts in an exercise of power. When we define or represent something in a particular way we are producing a particular 'knowledge' which brings power with it. To construe the world in terms of those people who are 'risky' or 'not risky' brings with it a production of knowledge that has implications for inequities of power between these groups. Knowledge/power is not a thing; it is relational, productive, and strategic and it operates even at the most micro levels of social relations e.g. an interaction between patient and professional, not just localised in government and the state.

My adoption of a critical realist position enabled an examination of material implications and a broader understanding of how other material realities made certain constructions possible and delimits others. In line with the work by Lupton, I positioned this research from a perspective which asserted that the language of risk was not neutral, that it was embedded in social and political settings and used for certain purposes (Lupton, 1999) and therefore the use of language itself and its performative quality was the focus of analysis.

2.4 METHOD AND PRACTICE

2.4.1 A Tool Box for Cultural Analysis

In my examination I was looking for power in the way that Foucault conceptualised it. The key interpretations from Foucault in my examination were that power is productive and it can be enacted on subjects without force through self-disciplining practices. Foucault saw his ideas as providing a tool-box for others to draw from: *"I would like my books to be a kind of tool-box which others can rummage through to find a tool which they can use however they wish in their own area"* (Foucault, 1994, cited in O'Farrell, 2005:50). It was with this intention that my understanding and use of the following concepts in the analytical process is presented below.

2.4.1.1 Power

Foucault is famously linked with the notion of power; namely the idea that knowledge and truth exist in essential relation with social, economic, and political factors (O'Farrell, 2005). An extensive narrative of his work on the subject is not possible or necessary for the purposes of this project, instead a brief description of how I understood the following concepts will be provided.

Foucault conceptualised power in a new way and while his own views on the concept altered throughout his career, the following is an attempt to amalgamate some of his ideas into conceptual tools for the purpose of my analysis of risk. A significant idea is his assertion that power in the present no longer derives from what he termed *'the sovereign'*; and that power is not simply something to be possessed by an individual or group to subjugate or repress another. Power is instead viewed as constantly shifting through ongoing interaction between circulating discourses. Foucault argued that power can only be exercised over free subjects; those that have the possibility of reacting and behaving in different ways and when this is closed down through violence or slavery, than this is an illustration not of power but of the limits of power (O'Farrell, 2005). Central to this is the idea that power is actually productive; it produces particular types of behaviour and regulates everyday behaviour through the proliferation of knowledge and discourses:

We must cease once and for all to describe the effects of power in negative terms: it “excludes”, it “represses”, it “censors”, it “abstracts”, it “masks”, it “conceals”. In fact, power produces; it produces reality; it produces domains of objects and rituals of truth. (Foucault, 1977, p. 194)

The nexus of knowledge/power is important to understanding the conceptualisation of power as productive as previously described in section 2.3. While power is conceptualised as dispersed and operating at micro levels as opposed to just centralised, Foucault acknowledged that there is a hierarchy of knowledge/power relations whereby some knowledge/power are considered more legitimate and therefore more dominant than others. The relative legitimacy and dominance of any given discourse is, however in constant flux, creating power relations that are unequal because certain knowledge/power comes to be privileged over others at certain times (Foucault, 2003b).

2.4.1.2 Disciplinary Power

I understood disciplinary power as something that works in relation to what Foucault termed older forms of ‘sovereign power’, operating from a central authority figure. New forms of social control were developed aimed at regulating the behaviour of populations, beginning in the army, the school, and then hospitals, factories, and prisons in the 17th century. These mass forms of training of bodies and behaviours was argued by Foucault as producing ‘docile bodies’ whose economic and social usefulness could be maximised (O’Farrell, 2005). The organisation of space, the concept of ‘enclosure’ in institutional places for criminals in prison, children in school, workers in factories etc. and the organisation of group activity through timetables and training were instrumental in this technology of disciplinary power and control .

The effectiveness of disciplinary power was guaranteed by technologies of general surveillance. The notion of the ‘gaze’ and technology of surveillance derived from the idea that people behave in a particular manner if they think they are being watched. The concept is illustrated in the panopticon prison design by Jeremy Bentham in the 1790s whereby cells were grouped around a central guard tower; prisoners could not distinguish if the guard was looking at them and so started to behave as if they were being watched all the time.

Foucault and others have argued that this is a key principle on which modern society operates and that panoptic mechanisms are employed at work, in schools, hospitals, prisons, shopping malls, airports and in many public and institutional spaces (Foucault, 1977). It means there is no need to challenge behaviour with threat or violence, just an inspecting gaze is enough for a person to change their behaviour.

2.4.1.3 Normalisation

Normalisation was thought to emerge from a shift in how violations and crimes were understood so that they were no longer just violations against the sovereign or the state but against society. To offend against the social body it was thought that one must be '*sick*' or '*irrational*', leading to ideas of a dangerous or monstrous individual (Foucault, 2003a). As a consequence an increasing number of experts were called upon to identify and categorise such individuals in terms of their deviation from a norm and Foucault asserted that '*like surveillance and with it, normalisation becomes one of the greatest instruments of power at the end of the classical age*' (Foucault 1977:184).

The power of normalisation imposes homogeneity whereby behaviour is observed, classified, examined, judged and rewarded on the basis of conformity. Also, deviances, differences and, eccentricities are ever more visible in a system that actively measures and seeks them out. Foucault argued that contemporary society had largely replaced legal notions of conformity to codes of law with medical notions of the norm, influencing ideas that criminals need to be not only punished for breaking the law but also '*cured*'. Consequently there is an inherent tension between a system based on law and a system based on medical norms in our legal and medical institutions.

What Foucault called the '*examination*' is a key technique in implementing normalisation and surveillance to '*establish over individuals a visibility through which one differentiates them and judges them*' (Foucault, 1977:184). In an examination individuals are required to reproduce knowledge and practices that are then measured and compared against other cases, creating further knowledge for fields such as psychology, psychiatry, and sociology.

2.4.1.4 Governmentality

My understanding of Foucault's concept of governmentality is that it operates not only through direct state sanction but through indirect shaping of free social practices on two levels; the level of the population and the level of the individual.

On the level of the population; techniques that focus on the management of populations (mortality, birth rates etc.) enable governments and other agencies and institutions to define a discursive field in which exercising power becomes rationalised and justified. By defining concepts and objects, it can provide justifications for what is been defined as a problem to be addressed; offering strategies and forms of intervention such as agencies, procedures, institutions, legal forms etc. in order to govern populations (Rainbow & Rose, 2006). For example the proliferation of expert knowledges on risk assessment provide guidelines and advice by which populations are then surveyed, compared against norms, and trained to conform with these norms. In light of this, *'risk may be understood as a governmental strategy of regulatory power by which populations and individuals are monitored and managed through the goals of neo-liberalism'* (Lupton, 1999:87).

On the level of the individual, *'the conduct of conduct'* a term that ranges from 'governing the self' to 'governing others' is understood to be not only direct intervention by specialised state apparatuses, as described above, but also the development of indirect techniques for leading and controlling individuals without at the same time being responsible for them. Foucault argued that, since the eighteenth century, this way of utilising power had achieved pre-eminence over other forms of political power (Rose, 1991). Rather than restrict people's freedoms through discipline, governmentality allows for the incorporation of these freedoms into the mechanisms that guide the behaviour of the social body. The governance of the 'conduct of conduct' through indirect techniques aims to construct responsible subjects whose moral quality is based on the fact that they rationally assess the costs and benefits of a certain act as opposed to alternative acts. These subjects therefore through self-determined decisions maintain the expression of free will and therefore the consequences for their actions is considered to be borne by the person alone who is solely responsible for them.

This is something that has arguably become a key feature of neoliberal forms of government (Rose, 2000) whereby responsibility is shifted to individual subjects and collectives e.g. family, for a range of social risks such as illness, unemployment, poverty etc.

The reduction in forms of welfare-state intervention can then be construed not as the state losing powers of regulation and control but rather a re-organisation of government techniques, which shifts the governing responsibility of the state onto the 'responsible' individuals (Lemke, 2001). This form of governance encourages individuals to see themselves as something to be constantly worked on in order to become responsible subjects (McNay, 2009).

2.4.2 Ethics and procedure

2.4.2.1 Ethics

Ethical approval for this project was granted by the University of East London Research Ethics Committee¹. The project was also approved and registered by the relevant research and development department responsible for mental health services in the area from which the participants were recruited². NHS ethical approval was not required to interview NHS staff because they are not considered vulnerable within the current ethical policies. Standard ethics protocols were followed, including gaining informed consent from participants both before and after the collection of data, adhering to confidentiality arrangements, and protecting the anonymity of participants. All names and identifiers have therefore been changed. Participants were informed that they were able to withdraw their decision to take part in the study at any time without consequence and obligation to give a reason.

2.4.2.2 Participants

2.4.2.2.1 Sample size

In terms of sample size, Ritchie, Lewis and Elam (2003) outline seven factors that might affect the potential size of a sample: *"the heterogeneity of the population; the number of selection criteria; the extent to which 'nesting' of criteria is needed; groups of special interest that require intensive study; multiple samples within*

¹ See appendix one

² See appendix two

one study; types of data collection methods use; and the budget and resources available" [p. 84]. I was mindful of these criteria, but was also not focused on sample size and did not have a target number of participants in mind. Given my methodological approach I was interested in the variety of ways that language was used not specifically in the users of that language (Potter & Wetherell, 1987).

2.4.2.2.2 Participant selection criteria

The multidisciplinary team is increasingly a key structure and process of collaborative working in forensic mental health settings (Carroll, Lyall, & Forrester, 2004) and consequently the concept of risk and risk related issues are regularly discussed and communicated between these professionals both in the context of formalised meetings and in more informal discussions. I sought to interview professional people who generally make up a multidisciplinary team as I imagined they all encountered issues and decisions about risk in varying ways. While significant decisions about leave (escorted and unescorted) and discharge from the institution are made with the input of multiple professions, psychiatrists make the final decision and consequently hold more accountability than other professionals. Therefore, psychiatrists were considered to be particularly key professionals to interview. It was thought that selecting a heterogeneous sample in terms of professional roles would maximise the discourses, subject positions and the ways in which risk is discursively constructed and this was the case as discussed in my examination of the data in chapter three.

The primary inclusion criterion was for the participants to be currently working as a mental health professional in a low or medium secure forensic mental health service. It was thought that being currently employed would improve the richness of the discussions as people would be able to draw on current and recent examples of clinical practice when talking about risk in a forensic context. The researcher was mindful of recruiting a range of professionals with varying levels of working experience.

2.4.2.2.3 Recruitment

A purposive sampling method including convenience and snowball strategies (Tashakkori & Teddlie, 2003) was utilised. The researcher had access to mental health professionals while working across a low and medium secure forensic

service as a trainee clinical psychologist. Participants were predominantly recruited via an email sent out by me to all psychologists working in these services with a request to forward the email to their wards and/or staff teams. The email provided a short description of the study with an information sheet³ and consent form⁴ attached. Those interested in participating were encouraged to contact me directly via email to arrange a time to meet and be interviewed. Seven out of the ten participants were recruited in this way. Direct requests for participation were made to particular people that I had come to know through working in the service, these were made via email and followed up in person.

2.4.2.2.4 Profile of participants

The participants were ten mental health professionals currently working in a low or medium secure forensic service; two Consultant Psychiatrists, one Consultant Psychotherapist, two Clinical Psychologists, one Occupational Therapist, one Social Worker, one Clinical Nurse Leader, and two Social Therapists. These professional disciplines were targeted as they are key professionals that make up multidisciplinary teams in clinical settings. They ranged in age from 25-50 years and included five males and five females. Six participants identified themselves as white British, one as Irish, two as white European, and one as Greek. The length of time that professionals had worked in forensic mental health settings ranged from eight months to 12 years.

2.4.2.3 Profile of researcher

I am a trainee clinical psychologist who was on placement at a low secure forensic service at the time of data collection. On reflection I had an early interest in psychology and the law when I considered undertaking a dual undergraduate degree in both fields. I pursued only the psychology degree and have on occasions regretted not taking that opportunity. My original interest in risk was in relation to generic mental health services, particularly working in a community mental health team where I was struck with how risk and quite often a preoccupation with accountability impacted on clinicians' work. A growing interest in critical psychology as result of my studies on the clinical doctorate

³ See appendix three

⁴ See appendix four

course at UEL led me to be curious about how the diversity of views and debated constructs of mental health are accommodated or not within a system inextricably linked to the law such as forensic mental health services, leading me to request a placement in this area. Throughout this research process I am aware of how my opinions and positions on certain issues have changed and developed. Throughout my studies I have grappled with social constructionist ideas about mental health in an attempt to conceptualise such things in a useful and clinically applied way.

As a trainee clinical psychologist on placement in the service I recruited from, I knew some of the participants interviewed as a result of working relationships. I was aware of my dual role; as a critical researcher during the interview process but also as a colleague who had a lot of respect for the participants being interviewed and from whom I was actively trying to learn from during my placement experience. I attempted to attend to issues such as these through the use of a reflexive journal (described in section 2.4.2.4). However, I understand that my interpretation of the data is likely to be coloured by own background and values and as a consequence I have for the most part included longer extracts in the analysis section that will enable the reader to contextualise the talk and perhaps draw their own conclusions on how I have interpreted the data and the conclusions I have made.

2.4.2.4 Data Collection

Material for the study was collected through conversational style interviews with the research participants. These interviews ranged in length with the shortest being 38 minutes and the longest 1 hour 12 minutes (average approximately 50 minutes). I gave participants an estimation of interview length (40-60 minutes) and natural endings to interviews were agreed between the participants and me. Each interview was recorded using a digital recorder and all interviews took place in the respective participants' work places at times convenient to them. Prior to the interview, I asked participants to sign the consent form and I explained of the limits of confidentiality. There was an opportunity for participants to ask me questions about the research at the end of the interview, and to reflect on their

experience of the interview process. A list of interview strategies⁵ was used to generate discussion with the participant, given the conversational style of the interview; the guide consisted of suggested topic areas for exploration rather than specific questions (Potter & Wetherell, 1987). I attempted to co-agenda the discussion and elicit from the participant any areas that they also thought were relevant to the topic. I provided space for the participant to take the lead on what was discussed by using open questions, prompts, and reflective listening skills to maintain the dialogue.

Given the epistemological approach underpinning the method there was no assumption that I was taking up a neutralist stance and the interviewing style was considered active with the interviews treated as a co-constructed locally occasioned research interaction. Consequently the researcher-interviewee relationship needed to be considered in the analysis. I maintained a reflective journal throughout the data collection process, attending to how I had engaged in the interview. Notes included thoughts and feelings generated as a result of the interactive process with the interviewee as well as comments and reflections on the content of the interview, any connections with previous interviews, the clinical psychology literature on risk in forensic contexts, and/or Foucauldian concepts; as I was subscribing to an iterative analytical process (Willig, 2001). This material was acknowledged in the analysis of the data as discussed in chapter three.

The decision to conduct individual interviews was made to allow participants more space for exploration and reflection on the topic, something that in naturally occurring data (clinical contexts of meetings and case discussions) would have perhaps been more constrained if they had to be taking up a certain role within a multidisciplinary team.

2.4.2.4.1 Transcription

The interviews were transcribed verbatim. A simplified transcription convention was used (as per Malson, 1998). This was because the research was not explicitly focussed on the use of rhetorical devices and speech patterns, but on broader 'global' discursive constructions (Malson, 1998). See appendix six for details of transcription conventions used. Participants were identified in the

⁵ See appendix five

transcripts by a code which represented their gender and profession with all other identifying details altered or omitted to ensure anonymity and confidentiality⁶.

2.4.2.5 Stages of Analysis

2.4.2.5.1 Reading

The aim of the analysis was to examine all the transcripts and the data set as a whole while also maintaining an analytical focus on the differences and similarities across different professionals' interviews. This two pronged approach to the analysis required consistent attending to. After transcribing each interview I read through it and made some notes of any themes, areas of interest, and links to previous interviews in a reflective journal. After all the interviews had been transcribed they were read through again to increase my familiarity with the data.

2.4.2.5.2 Initial Coding of Data

Each transcript was systematically read and coded utilising the methodological guidelines for conducting a FDA as proposed by Arribas-Ayllon and Walkerdine (2007) to identify Problematizations, Technologies of Power and Self, Subject Positions, and Subjectification⁷ and I colour-coded sections of text corresponding to each of these on paper copies of the data. At this stage additional questions were asked of the data as I went through each transcript including '*what is being constructed as risk?*' and '*how is risk being constructed?*'. I made notes in the left margin of the transcripts detailing the above and in the right margin I made notes on links to Foucauldian concepts and the risk literature⁸. In an effort to attend to not only the data set as a whole but also the account of each professional I extracted all the subject positions identified in each transcript and listed them

⁶ See appendix six for transcription conventions and participant codes

⁷ See Arribas-Ayllon & Walkerdine (2007) for more detail, definitions are taken from there.

Problematizations are examples where discursive objects are made 'problematic' and therefore visible and knowable. They often form at the intersection of different discourses and expose knowledge/power relations.

Technologies are practical forms of rationality for the government of self and others. Technologies of power seek to govern human conduct at a distance while technologies of the self are techniques by which human beings seek to regulate and enhance their own conduct.

Subject positions are not only the positions on which people ground one's claim to truth or responsibility, but they allow individuals to manage, in quite subtle and complex ways, their moral location within social interaction.

Subjectification refers to an 'ethics' of self-formation; how do subjects seek to fashion and transform themselves within a moral order and in terms of a more or less conscious ethical goal.

⁸ See appendix 7 for a visual representation of coding at this stage.

together for each participant to give me a sense of how each professional tended to position themselves.

2.4.2.5.3 Selection of Extracts

Transcripts were re-examined to extract data relevant to the subject of my enquiry, risk. From this examination initial themes were developed and extracts identified under them. For this stage the electronic copies of the transcripts were utilised and portions of text from a transcript were copied into another document under relevant themes. The portions of text were colour coded according to participant so I was aware of the interview each extract came from in this process. I used my coded paper copies of the transcripts, my own knowledge of the data, as well as the 'Find' feature in Microsoft word to re-examine and re-search each transcript for constructions of risk pertaining to each theme. This process enabled the development of a framework of the data set and to determine any significant differences and variations in the constructions of risk across the interviews⁹. Initial themes were as follows:

- Communication with other professionals
- Uncertainty
- Responsibility/ Ethics
- Harm to Self
- Harm to Others
- Relational
- Statutory Framework
- Risk Averse
- Therapeutic
- Violence
- Risk to Staff
- Lose sight of offence
- Importance in Service
- Tools/ Formalised
- Clinical Experience
- Unconscious/ Emotional

⁹ See appendix 8 for an example of one of these themes with colour coded extracts categories beneath it.

- Treatment
- Discharge Factors
- Communicating to patients
- Risk Factors
- Mental Illness V Personality Disorder

From these themes broader discursive sites were formed by reassessing the material, making links between themes, and mapping broader areas onto them that encompassed key aspects of the data set relevant to the construction of risk. These were 'Constructing the system as an inhibitor to meaningful information about patients and risk', 'The construction of risk to professionals through surveillance and accountability' and 'The construction of risk in relation to responsibility and as something that can be transferred' , these are addressed in detail in chapter three.

I re-examined the extracts using the information I had gathered in my initial coding of the data including what technologies of power were present and how this related to the Foucauldian concepts of interest. It was with these discursive sites in mind that the final selection of extracts was done in an effort to demonstrate how professionals had constructed risk in these particular ways. Throughout this process I tried to remain conscious of and manage any confirmation biases that I might be enacting on the data, only seeking out abstracts that fit a particular theme, by proactively reviewing the framework that I had developed for contradictory extracts in order to also demonstrate the diversity of constructions. I examined each selected extract in detail and a full account of this is provided in the following chapter.

CHAPTER THREE – ANALYSIS AND DISCUSSION

The analysis will be discussed and presented in this section. In doing this, reference will be made to the research sub-questions:

What is being constructed as risk and what is being problematized?

What technologies of power and self are being deployed in these constructions?

What subject positions and social practices are made possible from these constructions?

The analysis demonstrates how professionals working in this forensic service construct the concept of risk as nebulous in nature; whereby its definition, use, and function dramatically changes across contexts. Despite this variability in how the concept is constructed and functions, an acknowledgement of its powerfulness and impact on clinical activity was evident in the discursive constructions described in this chapter. The diversity of content in the interviews was perhaps in part due to the lack of clarity and multiple ways in which the language of risk is utilised.

The almost indefinable nature of the construct was reflected and commented on by some professionals.

Extracts: 1 and 2

08MClinPsy (Male Clinical Psychologist)¹⁰: ...the behemoth of risk which means nothing and means everything for people, it dominates everything and we don't quite know what we mean when we talk about it (229-230).

01MConP: I'm always thinking 'risk' is a thousand things to a thousand different people [yeah] so I mean it depends, what's the risk today [ok], what are we worried about today(180-180).

¹⁰ See appendix six for participant coding details.

Here the psychologist constructs risk as something that dominates everything but its meaning is unclear when professionals talk about it. Similarly the psychiatrist makes reference to this lack of clarity as a consequence of the ways in which risk can be constructed by different people; *'risk is a thousand things'*. These views are perhaps dissimilar to the risk literature which is predominantly comprised of the academic pursuit of clarity in the face of risk and uncertainty, with the proliferation of risk assessment tools. The implications of such divergent constructions are continuously examined throughout this chapter.

Three discursive sites will be presented and should not be considered separate but rather interconnecting discursive spaces on how these mental health professionals construct and produce the concept of risk. These have been termed: 'Constructing the system as an inhibitor to meaningful information about patients and risk', 'The construction of risk to professionals through surveillance and accountability' and 'The construction of risk in relation to responsibility and as something that can be transferred', these will be addressed in turn in the following section.

3.1 Constructing the system as an inhibitor to meaningful information about patients and risk.

An observation made by professionals was the difficulty in negotiating and interpreting information in an effort to ascertain an assessment of risk with their patients given the particulars of their service context; a secure forensic service. The complexity of the system and the unusualness of the context were referred to as sometimes inhibiting clear understandings of their patients and consequently any risks associated with them. The *'dual responsibilities'* (08MCLinPsy; 261) of professionals who are made to enact roles and practices in an institutional setting at the nexus of knowledge and power of both a health and judicial framework was highlighted and problematized.

3.1.1 Forensic context as an intersection of two systems

Extract: 3

08MClinPsy:...we sit on the sort of borders between two very different systems [hmm] one is the health system which I guess is about caring, about combining health services whatever that might mean and the other one is a legal system which is about very rigid boundaries, it is about punishment and is about consequences and is about [unheard] in the current legal system we working also about prevention of something happening so they are quite different and we have to be aware of both of these responsibilities and it's very hard to straddle that all the time and what I think is you always have to think about the third position in the room we can't just, we don't have the luxury of being just a therapist, we don't have the luxury of being just a custodian, we're both and we are both all the time (237-245).

Here the working context and the responsibilities of professionals are constructed as complex and inherently hard to navigate because '*we don't have the luxury of being just a therapist, we don't have the luxury of being just a custodian, we're both and we are both all the time*'. This locates him in a position of someone who must manage the inherent complexities of a role made possible by this intersection of institutional technologies of power. He goes on to say, *it's not that one has more of a right to exist than the other, they both exist, both is what society feels is the appropriate way of going about our business* (259-261). The construction, here, of two different systems; one about health and caring, the other about legalities, punishment, and consequences echoes broader commentaries on the contradictions that is seemingly evident in modern discourses of crime control (Rose, 2000). The offender is viewed both as someone that needs to be re-trained and/or someone who is stigmatised and needs to accept moral culpability. The discourses of both reintegration and moral punishment create a modern view of crime control that espouses community responsibility for the acts of offenders while also producing and promoting increased punitive measures (Rose, 2000).

The competing and seemingly contradictory practices that are made possible by such discourses are understood by Rose (2000) as the result of how the subjectivity of an offender has come to be understood and constructed. In what Foucault describes as the shift from sovereign to disciplinary forms of power and the emergence of practices that promote self-disciplining individuals through disparate forms of normalisation and surveillance (described in section 2.4.1), a shift in the possible subject positions of offenders has occurred. Transgressions or offences by individuals are not just considered violations against a sovereign but against the whole social body and as such the image of a perpetrator is not only a juridical subject of the rule of law or a psychological subject of criminology; they are an individual who has failed to accept their responsibilities as a subject of a moral community (Rose, 2000). This construction of an offender makes possible ethical reconstruction through shaming or reform and also increased punitive measures due to the conceptualisation of the offender as a violator of moral obligation to others. That is, the control of crime and bodies is linked to 'violating the assumptions of subjectivity- of responsible morality, self-control and self-advancement through legitimate consumption- upon which contemporary strategies for the government of freedom have come to depend' (Rose, 2000:237). This notion of subjectivity as responsible neo-liberal subjects is reflected throughout the data and will be explored further in section 3.3 in relation to the discursive construction of risk in relation to responsibility and as something that can be transferred.

Forensic services operate at the nexus of '*two different systems*', these seemingly conflicting practices emerge out of the subjectification of an offender in this way. This psychologist later offers his conceptualisation of the subject positions made possible for professionals given the complexities of the working context; '*identifying too much with the sort of the custodian role*' (267) or '*people talk about you know they are a nurse and that they are only here to care for someone*' (271-273) and how acting out of only one of these positions can become problematic; '*the polarisation is maybe what I notice more that can be really unhelpful in terms of clinical decision making*' (278-280).

The difficulty in maintaining the complexity of professional roles and instead acting out of positions reduced to a binary was also reflected on by other professionals.

Extract: 4

07FClinPsy:...finding a balance sometimes it quite hard so either people can be risk averse, very risk averse and kind of interpret everything as risky just because you know people aren't allowed to have a wobbly day or kind of reading too much into things and not thinking about that particular person's individual formulation losing sight of that, a bit um or it kind of goes the other way not thinking enough about risk [yeah] being a bit sort of drawn in and a bit blasé a bit desensitised with whatever [yeah ok] and it is you know it is difficult to keep all those things in mind... (56-61).

Here, the construction of a binary; *'people can be risk averse'* or *'not think enough about risk...a bit blasé desensitised'* echoes the problematization of only taking up one role or the other. This is constructed as a consequence of *'not thinking about a particular person's formulation'* whereby the construction of an individual formulation to make sense of a person is made into a technology of power to assist in the management of what is considered to be a complex task. The psychologist positions herself away from and problematizes notions of generic 'risky behaviours' and emphasises *'individual formulation'* as a key practice. The difficulty in holding the complexity of patients in mind was continually referred to.

Extract: 5

02FOT:...some people where you have known them for kind of a long time that becomes difficult to keep the risk aspect in mind a lot of the time where you actually you know I think sometimes you think that your relationship with someone is more of a protective factor than it is... (213-216).

Here, this occupational therapist, is constructing risk as something that is difficult to keep in mind when you have known a patient for a long time which has implications on her subjective experience as a clinician whereby *'you think that your relationship with someone is more of a protective factor than it is'*. She comments on the fact that with some patients she can on occasion forget their index offence because it does not *'feel relevant day to day'* (231) and that risk and someone's offending potential is *'something that you need drummed in again and again'* (220). Navigating an institution that propagates complex dual roles; whereby as a professional you have to develop therapeutic relationships with patients *'whatever the risk is'* (228) has consequences for how the production of knowledge of a patient is used by professionals. Again the binary notion is referred to when this occupational therapist refers to *'the person on paper and the person you meet'* (221-222), this separation of the patient from their offending behaviour that is written on their 'file', potentially because of the difficulty in tolerating and conceptualising them together, enables a practice that she goes on to describe of considering whether new students in the service should meet patients before or after they *'read the files'* (224). The implication is that the students' ability to form a relationship with a patient might be hindered by knowledge of them acquired through reading their file. This practice was also referred to by a Social Therapist, *'we try here not to look at the index offence as you know because a lot of people would look at that and think oh manslaughter I'm keeping my distance from him try and get to know the patient first and then read up on the history maybe a day later'* (06FST:69-71). The production of knowledge that occurs in terms of what is recorded on patients' files and its implications on the patient's subjectivity is also referred to in extract 11.

Practices that seek to clarify what is seemingly unable to be clarified in what is such a complicated and unusual environment in a forensic service were regularly commented on. The institutional context was constructed as something that inevitably obscures a professional's ability to assess or understand risk and therefore awareness of this was constructed as almost essential and techniques and practices to negotiate and resist this were highlighted.

3.1.2 Disconnection between the institution and the community

In the following extract this psychiatrist acknowledges the '*unusual and highly restricted environment*' that is a forensic secure service and how this can inhibit a professional's capacity and indeed a patient's ability to reasonably make predictions about the future likelihood of a patient's behaviour and potential adverse outcomes.

Extract: 6

01MConPsy: My experience is that people, change in unpredictable ways once they are outside of hospital and that's not surprising really because you know you are asking them to have a leap of imagination where they imagine living in the community when in actual fact they've been in a very unusual and highly restricted environment [sure] for years and years, they, you can prepare them all you want but the reality of living in the community is different to being here (316-321).

This '*leap of imagination*' that he describes problematizes the efforts made to assess and predict someone's behavior and potential risk of adverse outcomes when these occur over two different contexts; the institution and the community. The relational component of behaviour and risk is acknowledged; namely that the institutional context itself is instrumental in producing certain patient practices and behavior that will therefore not always translate or be produced in another community context. The influence of the institutional context and how this might impact on a patient's subjective experience while in a forensic service, and consequently a professionals' assessment of them is something that is infrequently referred to in the literature on risk assessment. The radically different conditions of an institution and a community context were made explicit by this recounting of a patients' view to this social worker.

Extract: 7

10FSW:...he said "before you come and work on the wards go outside and see the crack houses that we come from, go work in community and see the crack houses that we come from or the poverty that we come from

[yeah] and then you'll know a little bit about us, where you come from, coming onto the wards, you don't know me" [hmm] and never a truer word be said [yeah] never a truer word be said and when he was eventually discharged he went straight back to crack cocaine use and passed away from a heart attack and I'll never forget him because never a truer word be said, institutions are often white middle class places [yeah] services users depending on the area are often Caribbean background, Afro-Caribbean or British Caribbean, some African, large populations and we're treating them and we don't know them (309-318).

The disconnection between the social contexts that professionals and patients occupy is made problematic. Here, not only is the institutional space itself constructed as an inhibitor to knowing patients, the wider social inequalities namely the operation of race and class also are problematized.

There is a body of research that indicates that Black people are over-represented in mental health services in the United Kingdom and over-represented at each heightened level of security in the psychiatric process from informal to civil detention, and then in detention on forensic sections within the courts and criminal justice system (Bhui, 2001). They are more likely to enter the mental health system from a criminal justice context and they are more likely to receive coercive forms of treatment including physical interventions of seclusion and restraint and less likely to receive psychotherapeutic interventions (Healthcare Commission, 2007). The relationship between mental health services and Black communities has been described and understood as one of distrust; whereby Black people mistrust and often fear services, and staff are often wary of the Black community, fearing criticism and not knowing how to respond, and being particularly fearful of young Black men. The cycle is fuelled by prejudice, misunderstanding, misconceptions and sometimes racism (The Sainsbury Centre for Mental Health, 2002), something that is suggested in the following extract.

Extract: 8

10FSW: I was in a meeting once at '*service name*' with the consultants and there was a general mocking of the patients, the way one of them

speaking, and language was quite racist, quite derogatory, [yeah] and these are the, this was the body of people that was responsible for their treatment [hmm] for assessing them, treating them and discharging them [hmm] and that was there regard for them [yeah] I think if you don't really know them how can you assess their risk...(322-326)

The use of the term 'them' in this extract is striking and serves to other 'them', the patients, as explicitly distinct from the professionals. Here risk is being constructed as something that is unable to be assessed in the context of racist and derogatory language of professionals about their patients. Through institutional practices and continual examination enacted on patients by professionals, patients become a site of knowledge and power, whereby the production of knowledge about them becomes privileged by those producing it. Here, this social worker reflects on the prejudice she has been witness to and not only questions the morality of it but also how it obscures a professional's ability to assess risk; *'if you don't really know them how can you assess their risk'*. The reference to the institution and those in it as a unique context and further complicating the assessment of risk was also referred to in this next extract, in which the focus is on the patient.

Extract: 9

03FConPsy: I think the hospital sort of they contain and crush a little bit so you don't actually see the full picture, I don't think, you see a sort of lesser, lesser version I think you know lift the lid you know the madness becomes much more apparent [yeah] so um for some people it's too much a move like that whereas for some people it's, they actually get, they are better um they are less anxious so their psychosis is actually improved but you can't tell if you are going to be sort of well actually being a bit freer makes me more anxious or being a bit freer makes me less anxious it's quite difficult to know which way they are going to go [yeah] so you have to be you know you have to know that there is a pathway back for that group (295-302).

This extract constructs patients as being able to be moved through to lower levels of security in the service and the implications of less restrictions and more freedom on their mental wellbeing and risk. This psychiatrist constructs the hospital as something that obscures her ability to '*see the full picture*'; here, the emphasis is less on how professionals or the institution itself aids in the production of certain knowledge about patients and risk as in the previous extracts. She constructs the institution as something that contains and crushes so you see a '*lesser version*' of the patient, still locating the madness and the consequential risk in the patient. By constructing it in this way she acknowledges its impact on patients' presentation and the uncertainty of whether '*being a bit freer makes me more anxious or being a bit freer makes me less anxious*' while still maintaining the view that the madness or indeed the riskiness resides in the patient and the institutional context and practice can '*crush*' this in a way that either produces more anxiety or less. In this way the tiers of security integral to a forensic service are warranted; '*you have to know that there is a pathway back for that group*' whereby the critique of the system also acts to rationalise and reinforce its processes. In the same way that perhaps '*the failure of risk assessment and risk management is no threat to such logics, merely a perpetual incitement for the incessant improvement of systems, generation of more knowledge, invention of more techniques, all driven by the technological imperative to tame uncertainty and master hazard*' (Rose, 1998b:190).

This echoes modern theories of managing and controlling risky individuals whereby services have been redistributed with various levels of security with the belief that different regimes of control are appropriate for different conditions, that these services are fluid and people should move between them (Rose, 1998b; Joint Commissioning Panel for Mental Health, 2013). This sentiment also feeds into the task of producing a subject that self-disciplines itself; the constant fluidity and shifting of the associated practices in each level of security is a technology of governmentality; tailoring the level of institutional practices on the conduct of patients given the perceived ability that they have to maintain their own 'conduct of conduct'.

3.1.3 Risk and therapeutic value in opposition to each other

The construction of risk as something that can inhibit therapeutic value in the service and thus obscure the assessment of a patient's risk was reflected on and made problematic by some professionals.

Extract: 10

08MClinPsy: ...therapeutic initiatives that can be stopped, can be sort of you know before they even exist, the idea it can be snuffed out if just someone says it's too risky or you know we have a risk assessment or someone makes therapeutic progress, risk can sort of counter-balance that (94-97).

Here risk is constructed as something that sits in opposition to therapeutic progress, something that can inhibit therapeutic programs or '*initiatives*' if '*someone says it's too risky*' and something that can '*counter-balance*' what he views as a patient's '*therapeutic progress*'. The implications of this are explored in terms of the '*double bind*' this creates for patients in the following extract.

Extract: 11

04MCPsythe:...so we end up in sort of collusion sometimes with them to not talk about the problem, to not talk about the pain and to not talk about the trauma and partly I think that is the case because the systems work in such a way that if these people do talk about the pain and they do talk about the trauma they usually get very angry and very upset and very distressed and if they get very angry and very distressed and very upset we immediately start to think that they are getting worse [yeah] and that their risk has gone up and that we write down 'aroused' 'angry' 'threatening' 'difficult' [yeah] and so we put them in a double bind and I think this is a regular experience that we say you need to be honest and straight forward and face up to the pain knowing that if and when they did that they are likely to act out and if they act out then we take this as

evidence that they are risky rather than think that actually this is a necessary process...(103-112)

Again, risk is constructed as something that is in opposition to what this psychotherapist understands to be a '*necessary process*' in therapeutic work. The '*systems*' within the institution are problematized for responding to and interpreting anger and patient distress as an increase in patient risk. The practices that this conceptualisation warrants include writing down '*aroused*', '*angry*', '*threatening*', and through this act of productive power, knowledge about the patient is produced and in that, power '*produces reality; it produces domains of objects and rituals of truth*' (Foucault, 1977:194) and makes that patient 'high risk'.

What is constructed here as a '*double bind*' is perhaps a representation of broader contradictions in crime and control in modern society; '*new political rationalities, including crime control come to be articulated in terms of this distinction between a majority who can ensure their own wellbeing and security through their own active self-promotion and responsibility for themselves and their families, and those who are outside this nexus of activity: the underclass, the marginalised, the truly disadvantaged, the criminals*' (Rose, 2000:331). These excluded populations are deemed non citizens, or failed citizens, conceptualised as those who are unable or unwilling to enterprise their lives and manage their own risk by exercising responsible self-government (Rose, 2000). They are subject to strategies of control that on the one hand seek to re-affiliate them, through principles of activity, to reattach them to circuits of civility, in this case; '*being honest*' and '*facing the pain*', to work on oneself to resume responsibility of the self. On the other hand there are also strategies which consider re-affiliation impossible and instead seek to manage these anti-citizens and marginal spaces through measures that seek to neutralise the dangers they pose e.g. '*three strikes*' policies, strategies for preventable detention etc. (Rose, 2000) and in this case, responding and producing the knowledge that a patients '*risk has gone up*' and therefore they require further restrictions.

This psychologist reflects on how his view of therapeutic progress, the value of working with and through emotional processes and high affect, is inhibited by a

system that emphasises identifying and managing what might be considered risky.

Extract: 12

08MClinPsy: I guess think about expressing anger is a good example [yeah ok] I think in a setting like this if you start to work in a therapeutic approach where affect is actually encouraged and you want to work with it because you believe that's how change actually takes place rather than through cognitive processes, it takes experiential processes through affect and you sit in a room and someone shouts at you and then someone storms in and intervenes or is worried that something might happen it's not helpful [yeah] it gives the wrong message, you can't do anger management in a MSU I think [both laugh] strangely (99-105).

Here the expression of anger in a secure forensic setting is made problematic and the institutional practices of '*someone storms in and intervenes*' are then warranted. This psychologist experiences this as unhelpful and giving '*the wrong message*' to patients who are both compelled and inhibited to engage in difficult and painful psychological work. Leading him to conclude '*you can't do anger management in a MSU*' (medium secure unit) and laughing perhaps at the apparent irony of the situation. This tension and the potentially limiting factor of psychotherapy in a secure setting is acknowledged elsewhere; '*forensic psychotherapists working in secure settings, issues of security are omnipresent and, at times, are in tension with the task of delivering treatment*' (McGauley & Humphrey, 2003:120). The therapist's task is highly complex in order to potentially differentiate between a patient who has made what might be considered significant psychological progress, the patient whose level of distress is high, and one who perhaps considers themselves to be better and is instead engaged in some sort of conscious deception or an unconscious pseudo-compliance to what he perceives is expected of him.

The implications of such a system with competing agendas are reflected on by this social worker in what she understands as the creation of a '*tick box*' process that occurs in forensic services.

Extract: 13

10FSW:...sadly I think being in forensic services a lot of the services users know how to say this, this, and this, it's a tick box to get out [hmm] that doesn't necessarily mean they believe that tick box all the time or that's the way they are feeling about things (72-75)... they learn about the system [yeah] and some people whether it be youth, personality, background, try to fight it for a while I think [yeah] but I think it doesn't take long for people to realise that actually you can't really fight it that yeah I think provides some tension in how well we know our clients (83-87).

Here the potential implications of what was characterised as '*collusion sometimes with them to not talk about the problem*' (04MCPsythe:103) are reflected on in the above extract. These 'tick box' processes are problematized and arguably restrict '*how well we know our clients*' and indeed how effectively professionals can establish the associated risk of patients who '*learn about the system*'. The system is constructed as a '*tick box to get out*' which inhibits a professional's capacity to know if their interactions with patients and the behaviour of patients is actually based on what '*they [patients] believe*' (74). She constructs the system as something that cannot be fought by patients, who soon learn to produce and perform to the perceived expectations of professionals.

This does not support a system that genuinely encourages honesty; it is a system that involves perpetual surveillance that is engaged in the production of risk knowledges. Professionals were often not naïve to such dilemmas and the limiting nature of them, constructing ways of negotiating a system that at times was considered to be highly conflicted.

Extract: 14

02FOT: ...one of the things that I find frustrating is the idea of insight and what that is because a lot of the time it's about reciting the right thing at the right time (365-367)... we were sort of ready to discharge him but you knew that he didn't believe anything at all to do with his care, you knew he

didn't believe that he had mental illness, you know he didn't want to take his medication, you knew all these things but at the same time to be fair, he's ready to get out and he had a tribunal and there was this sense of you know please just don't say 'I'm not mentally ill', I don't', [chuckles] you know just don't say it and get through it and then you can get out and go and believe what you want but just kind of get through it and I think sometimes I think it's not always about what's meaningful and I think in some ways the system doesn't necessarily encourage you to be honest, it encourages you to say what you know the right answer is...(369-377)

Here this occupational therapist reflects on how the system problematizes someone who might say '*I'm not mentally ill*' at a tribunal tasked with the role of recommending discharge or not. She highlights the disciplinary practices that are required of patients to '*get through it*' and move out of a system that '*doesn't necessarily encourage honesty*' but rather having the right kind of performative practices. The means by which a patient is deemed appropriate to move out of such a system is positioned as something unique and separate from the community context where he can perhaps '*get out and go and believe what you want*'. The requirements of patients and professionals and the implications on meaningful engagement and useful information about risk are reflected on in the following extract.

Extract: 15

04MCPsythe:...I think that's the that's the sort of conundrum I think that we put people into I had a supervisor who worked at '*London High Secure Unit*' and he used to say something that I always remember when I think about risk so he would say 'we know for a fact that 50% of the patients in '*London High Secure Unit*' could be released tomorrow and that none of them represent any risk to society whatsoever we know that for sure, the trouble is we don't know which 50%' and that's the problem [yeah] and so I think most of the time we are guessing actually and I feel that part of that is that the system requires us to guess and requires us to sort of fill in forms that I think are not as meaningful as they could be...(133-141)

Here risk or the assessment of risk is constructed as *'guessing'*. The capacity for professionals to predict adverse outcomes on behalf of their patients is characterised as chance with the use of an anecdotal quote from a former supervisor; *'we know for a fact that 50% of the patients in 'London High Secure Unit' could be released tomorrow and that none of them represent any risk to society whatsoever we know that for sure, the trouble is we don't know which 50%'*. The system is constructed as problematic and instrumental in promoting a practice of guesswork whereby the forms that are designed to reduce 'chance' decisions actually produce them; *'requires us to guess and requires us to sort of fill in forms that I think are not as meaningful as they could be'*. The functionality of the *'forms'* that are constructed here as not *'meaningful'* is perhaps a view consistent with the advent of professional bureaucracy whereby professional practice is written and routinized with the primary aim seemingly to create defensible decisions not necessarily accurate decisions (Szmukler & Rose, 2013). The disconnect with what is understood to be a *'meaningful'* understanding of a patient and associated risks is something that was also continually highlighted in the discursive construction of risk as something that professionals themselves were vulnerable to in terms of the surveillance of their own practice.

3.2 The construction of risk to professionals through surveillance and accountability.

The construction of professionals themselves feeling as though they were professionally at risk and were being evaluated, surveyed, and scrutinised was striking.

Extract: 16

03FConPsy: Yeah I think over the last, well I've been a consultant for the last 10 years and certainly over the last 20 years um you know things have really changed dramatically I think in terms of the emphasis on managing risk and people making sure they've noticed that you've managed risk so it's not just you do your risk meetings, you know you make a note of them you have uploaded on the electronic record system, then anyone can see that you've done it when you've done it and how well you've done it [sure]

and if you haven't done it, and something happens then questions will be asked, there are huge systems now to make sure that a) you are doing it b) you are doing right, you've documented it and it's all there for everyone (70-77).

Here risk is constructed as something to be '*managed*' by her, the psychiatrist, and that its management by her is in turn managed by '*huge systems*'. The act of continuous record keeping is being constructed as problematic; to not only do your job, '*do your risk meetings*' and also be required to demonstrate you have done it '*uploaded on the electronic record system, than anyone can see that you've done it, when you've done it, and how well you've done it*'. She is positioned as someone about whom '*questions will asked*' if she does not comply with these systems and procedures.

In extract 16, an operation of disciplinary power at the level of the professional is visible and something that emerged in other parts of this transcript and the data set as a whole. The disciplinary power inherent to the institution itself; an enclosed space with a multitude of practices and techniques enacted by and through professionals to control patients, is also evident and being enacted on professionals through the surveillance of their practice and recordkeeping. This is reiterated and expanded in other parts of the transcript in which bureaucracy and accountability are problematized and she is positioned as someone who's professional identity is being eroded and made vulnerable by the institution's attempts to govern her activity; '*the status of what you know is massively undermined by all this accountability sort of stuff (101-102)*' and '*it doesn't matter how much you know, or how much you've trained, you know unless you've done this by a certain time we don't want to know (102-104)*'.

Arguably there has been a transformation of professional subjectivity whereby risk management, identifying and assessing in an attempt to limit poor outcomes, is increasingly a key part of psychiatry's role (Castel, 1991). Professionals' activity is being governed at a distance through real or imagined fear of prosecution from patients and public enquires (Rose, 1998a).

Extract: 17

03FConPsy: Well I feel more worried about the institution's response, the institution didn't, they used to be more benign whereas now it's this sort of crushing, oppressive, investigating, punishing sort of horrid parent figure whereas it didn't, it used to support loads of clinicians [yeah] in a bit more of you know laissez faire and you know just be creative and autonomous in your own way, so it is a different sort of response (115-119).

Here the institution as '*crushing, oppressive, investigating, punishing, sort of horrid parent figure*' is being problematized and she is positioned as someone whose creativity and autonomy has been restricted unlike earlier in her career when '*no one seemed to mind about risk (48)*' and '*people accepted I think that there would always be lots of incidents (53-54)*'.

Written and routinized assessments function as a way to ensure decisions are defensible in the face of these threats to professionals rather than primarily being an aid to making useful and accurate decisions. Professionals are potentially caught in a blaming system in which every misfortune is turned into a risk that is potentially preventable and therefore someone should be held accountable (Rose, 1998a).

Perhaps unsurprisingly the other psychiatrist who was interviewed reflected on the effect that potential inquiries had on his professional activity.

Extract: 18

01MConPsy:

I've been subject to an number of inquiries after things have gone wrong with my patients and that does that you've got to guard against that coloring your judgment and pushing you into a very risk averse position so you're thinking about risk assessment those factors are important because they potentially influence the decisions you make (412-416).

The inquiry as a disciplining technique is regarded as something that needs to be '*guarded against*' and he positions himself as someone who needs to resist the conditions made possible by such procedures; becoming '*risk averse*'. He

elaborates on this and says *'there is a tendency then to nullify risk and to act in a way that is much more risk averse and then you think you are saving the world but actually you're not you are just imposing unnecessary restrictions on people (396-398)'*.

In the United Kingdom, the public inquiry, conducted in a quasi-legal manner, has become a routinized response to untoward incidents. The procedural recommendations of these inquiries despite not being legally sanctioned have been instrumental in the proliferation of risk assessment, risk management, and risk thinking in the professional judgement of all mental health professionals (Rose, 1998a). The activity that professional's engage in is significantly impacted whereby the ever-present '*gaze*' of disciplining power is present. The merits of homicide inquiries on what are 'worst outcome cases' and their inherent hindsight bias, the assumptions they make about who are, or are not, active parties in an event, and where responsibility is located is questioned in an opinion paper by psychiatrist, George Szumukler (2000). He highlights the absurdity of some of the processes, the unlikelihood that they would occur in other disciplines, and how they perpetuate the stereotype of the '*dangerous individual*' fuelling public fear and stigma. In the following extract the same psychiatrist makes reference to his consciousness of how an '*observer*' might view professional discussions on risk and granting a patient leave.

Extract: 19

01MConP: I'm aware myself that the discussions that we have in those meetings is necessarily limited by time ah but you know I think if you looked at those discussions from outside you would think that they were pretty light on detail sometimes so I think sometimes we reach a decision and um it might well be the right decision but it's sometimes unclear why we've reached that decision

R: Ok so the mechanism or the pathway that lead to it doesn't feel, do you think it is unclear to you or unclear to most people in the room as well

01MConP: Well I think it would be unclear to an observer you know it's often clear in my own mind how we've come to that decision but my

concern is that often I come to that decision via a different route to other people and say if you actually sat us down at the end of the meeting and actually asked the question 'why'? My answer would be different to your answer.

Here the notion that discussions about risk in multi-disciplinary meetings might be considered '*light on detail*' to an outsider is problematized and potential justifications for this '*limited by time*' and assurances that despite this '*the right decision*' might have been made. The '*gaze*' of an absent observer is raised in his consciousness and his own reflections on this serve to exercise surveillance against himself. This perhaps inevitably shifts the focus and the aim of clinical activity from connecting to patients in an attempt to come to a useful and reasonable decision to establishing if a clear account that would be justifiable to an external other has been created.

The impact of perceived professional threats in terms of accountability was recounted by other professionals too, including this social worker.

Extract: 20

10FSW: And I've certainly used the mental health act to my advantage because I was fearful of possible reoffending (231-232)...I thought the CTO would be a safeguard to get him back in quickly [yeah if need be] yeah and he's someone that I still bear in mind to now I haven't quite let go [laughs] of am I in the clear [ok] so yeah I've certainly used the mental health act to safeguard myself as a professional and I think the public, I think (241-244).

Risk here is constructed as '*possible reoffending*' and she refers to her enactment of the mental health act and the use of a community treatment order (CTO) as both a technology of power to govern the behaviour of the patient; '*I thought the CTO would be a safeguard to get him back in quickly*' and a technology of disciplining the self; to '*safeguard myself as a professional*'. She goes on to say that it was also used as a safeguard for the '*public, I think*'

illustrating the administrative role of the mental health professional for *'public safety'* and how this can be potentially used to rationalise patient restrictions while safeguarding perceived risks to professionals themselves.

CTO's were introduced into England and Wales in 2008, an order that warrants compulsory supervision and treatment in the community with the aim of reducing hospital admissions. This social worker here, is positioned in such a way that she communicated her intension to actually use the measure to recall the patient to hospital; *'get him back in quickly'*, indicative of the longstanding debate on the evidence and ethical concerns over coercive treatment in the community (Lawton-Smith, Dawson, & Burns, 2008). Recent evidence suggests that despite a marked increase in CTO's (Health and Social Care Information Centre, 2012) they do not reduce admission rates (Burns et al., 2013). The ethical implications of this and the potential for professionals to use such measures to temper their concern of professional scrutiny if an adverse event were to occur echoes the sentiment referred to earlier, by one of the psychiatrists; *'you think you are saving the world but actually you're not you are just imposing unnecessary restrictions on people'* (01MCP:397-398).

Professional attempts to safeguard their own accountability were also evident in this account of nursing staff showing a reluctance to make a decision and *'sign'* off leave for patients.

Extract: 21

07FClinPsy I've heard people say "well I'm not, I don't want to sign, put my name on the paper work, I didn't, I wasn't sure, and you know anything can happen" and it's not really yeah so just not feeling comfortable um in making those decisions (145-148).

Here, this psychologist is problematizing what she understands as a tendency for nursing staff to assume that particular patient's behaviour on the ward will be problematic on community leave and therefore they withhold it. The nursing staff invoke their access to power and governing of patient bodies through a type of pre-emptive detainment in the name of community protection and most explicitly

to safeguard themselves by not wanting to '*put my name on the paperwork*'. In the following extract increasing demands on nurses to engage in bureaucracy to guard against professional risk is also made problematic.

Extract: 22

05MCNL...who are all just acting out of being overwhelmed by what is actually or what should be a rewarding job everyone says 'why do you do nursing oh that must be so rewarding', if I had the job time to do it when I was paper work and reading this and writing that and doing documents on 48 hour reports and all these different factors it's like the job's rewarding if we were allowed to do it [hmm] and I think that's something else I think you know frustration, anger at the system it's not healthy for people to work in an environment where they don't feel safe (381-386).

Here risk to professionals and their accountability in terms of their requirement to complete certain forms '*writing that and doing documents on 48 hour reports*' is being constructed as problematic and impeding on his capacity to have '*the job time to do it*'. He indicates that such an environment is not conducive to making professionals '*feel safe*'.

Efforts to negotiate a system that is perceived as potentially threatening to you as a professional in terms of accountability and provision of defensible decisions were visible as highlighted in extracts 19 and 20, and in the following extract.

Extract: 23

10FSW: ...you get some people that try and manage things a little bit manipulatively so the risk that doesn't sit with them but at the same time they take risks [ok] so Dr '*Smith*' for example wouldn't necessarily discharge someone but he'll speak in a tribunal in a way that encourages discharge but he's not recommending that and he would say that openly so I'm not taking his name in vain [yeah] so the blame doesn't sit with him if it all goes pear shaped(224-229).

Here, risk is being constructed as synonymous with '*blame*', as something that through certain actions '*doesn't sit with*' a certain individual. This provides a description of a doctor resisting the surveillance and governance of his practice that also tries to locate all consequences for his decisions on him as an individual. The doctor pushes back and resists this operation of power and the '*risk*' constructed here as '*blame*', is shifted to other decision makers, the tribunal. This strategy enables this doctor to do in essence what the nurses in extract 21 were unable to do; enable a certain action without putting a '*name on the paperwork*' (07Clinpsy:146), perhaps suggestive of the power available in the subject position taken up by a doctor in comparison to a nurse.

The discursive construction of risk as something that can be located in an individual or institution and that can be shifted between them was visible across multiple transcripts. It is a notion that in some instances acted to temper the feelings of accountability and potential blame held by professionals. This professional highlights the value in getting patients '*to take more of a role in their own management plans*' (442).

Extract: 24

02FOT: I found it quite reassuring so I quite like that we're not solely responsible for people's risks that they know it's their progress, it's their risk, they need to be proactively managing it and I find that's quite a useful way of thinking about things and I think about that more and more at the moment really you know you make your decisions, at the end of the day you are going to decide what to do [yeah] and I think that's quite nice, I like that and I think you can do that a lot more when you're not people's RC (responsible clinician) [laughs] I think that's the advantage (443-448).

Risk is constructed as something that is the patient's; '*it's their risk*' and they '*need to be proactively managing it*'. Constructing risk in this way enables the professional to position herself in a different way, to not feel the constraints of potential accountability and instead find it '*quite reassuring*'. This process reflects a broader process and agenda echoed across the transcripts whereby the institution and professionals seek to promote a self-disciplining subject in their patients. The status of institutional intervention shifts from direct efforts to detain,

enclose, and control their behaviour to more indirect technologies of the self. Wider neo-liberal forms of governance involving indirect techniques to lead and control individuals while also reducing responsibility for them is enacted in this discursive space. The emphasis on '*at the end of the day you are going to decide what to do*' enables the construction of the patient as a responsible subject whose consequences for actions are borne out by them.

3.3 The construction of risk in relation to responsibility and as something that can be transferred

The discursive construction of risk and associated responsibility as something that can shift from the realm of professionals and the institution to the patient themselves, and to other institutions and regulatory bodies is apparent in the following extracts.

Extract: 25

01MConPsy:...I guess those type of factors that I look for in terms of people being discharged are you know the risk factors for future violence being well managed the most obvious one for example being psychosis or something like that um a good structure in place in terms of day time routine and accommodation, some sense of community agencies being prepared to accept the risk that people potentially pose so hostel staff, MAPPA (Multi-Agency Public Protection Arrangements), the multi-agency public protection people, probation if they are involved and you know hopefully a capacity from the patient to not only manage their own mental health but also manage their risks, so awareness that they potentially pose a risk and some insight into the factors that are associated with relapse and the symptoms of relapse now I think in the real world sometimes you don't get that far...(274-283).

Risk here is being constructed in terms of '*risk factors for future violence*' and the practices that need to be employed for them to be '*managed*'. It is then constructed as something that community agencies are '*prepared to accept*'; the problematization of something in this case, risk, is highlighted, and made knowable and '*real*' to enable its transfer and associated responsibility to others. It is also constructed as something within the patient; '*their risks*', enabling the

consequential practice that is desired of the patient to have the capacity to *'manage their own mental health but also manage their risks'*. The demonstration of such a capacity is constructed as *'awareness that they potentially pose a risk and some insight'* echoing the idea of producing self-disciplining subjects that works on and governs themselves. The acceptance of risk by community agencies is an enactment of an increasingly dispersed gaze of institutions to measure and communicate about factors associated with an increased likelihood of undesirable conduct in respect to particular individuals. In terms of movement from the institution to community settings, risk is similarly constructed as on-going *'risk factors'* in the following extract.

Extract: 26

07FClinPsy:...so in order to manage you know the on-going risk factors that I think invariably everyone that is discharged present with because you know, you don't, you never have zero level of risk you just have kind of what's kind of good enough and is somebody going to comply, be able to be supervised in the community...(273-277).

The psychologist constructs risk as on-going factors that *'invariably everyone that is discharged present with'* and that the absence of risk is not possible; *'you never have zero risk level of risk'* which warrants assessments of *'what's good enough'* and practices of compliance and supervision in the community.

The potential implications of patient information and conceptualisations of risk as not as meaningful as they could be, as previously acknowledged by professionals, is experienced in the process of potential discharge from the institution to a community setting.

Extract: 27

07FClinPsy:...I think we did move someone on earlier this year who well he'd kind of sort of done enough but we did have concerns as to whether you know he really would comply because there was just subtle things about his personality, subtly very sort of, subtle underlying grandiosity,

superiority, you know feeling humiliated was a theme in his offence, he attacked this woman and you know you're sort of thinking about ok yes he's on medication, he's well, but you kind of worry about the fact, you know he doesn't, he thinks he was justified in what he did [unheard] you think well ok but he's going to a hostel, he's supervised 24 hours a day, supervised, taking medication, even though he doesn't think he should take it, he's got some activities and he did, and the things is there is that, it's very we like to say we work in a recovery focused way but really I don't think this chap had any choice really in the activities he took up because he probably really didn't want to do half of them but we just said if you want to get out you've got to do them so this kind of forced, enforced personal recovery [laughs] we'll change your life for you whether you like it or not but yeah again he's not able, you know it was just to avoid paralleling that the lifestyle that kind led up and precipitated the offence you know when he was isolated, alone, doing nothing in the community, nothing in his life and that's when this sort of grandiose delusions they filled the void...(353-367).

Risk here is being constructed as concerns about a patient's future compliance in the community despite his current compliance with some institutional practices and expectations of him. This patient is constructed as someone who has not done the work on exploring the meaning of his offence; the potential link between isolation, and grandiosity, and feeling entitled to offend, perhaps due in part to an institutional context that puts people in a '*double bind*' (04MPsythe:109) and inhibits this type of sense making because of the potential risks associated with it. Other institutional requirements and practices like taking medication and complying with supervision become positioned as a priority and attainable for the patient however their utility is still questioned without an indication of some kind of internal regulation of behaviour, or acceptance and understanding of their own actions and responsibility. This makes possible the requirement and practice of more external control agencies maintaining surveillance measures in an attempt to create and regulate a structured environment around the individual; '*I don't think this chap had any choice really in the activities he took up because he probably really didn't want to do half of them but we just said if you want to get*

out you've got to do them' to neutralise the questionable capacity of the individual to resist engaging in future offending and to disperse the perceived risk into a network of strategies around him.

The notion of risk being transferred from the forensic service and particularly the professional responsibility of the consultant psychiatrist is reflected in the next extract in which the professional conceptualises and constructs the process of discharge in terms of her own level of responsibility, accountability, and anxiety.

Extract: 28

03FConPsy: I've got a lot more experience of what can be managed in different settings [yeah] I think that's um because my training was very much high security, medium security so um and community psychiatry, general community psychiatry not really, I mean the sort of idea of forensic community psychiatry wasn't really around as much whereas now it's a bit more established and I've got quite a lot of community patients as well so um yeah I mean I hate now, I used to hate the discharge point, I now hate the point where they go from hostel to independent accommodation I haven't quite got that sort of shift I'm not quite ok with that shift but sort of moving to a hostel I'm sort of a lot less anxious about that than I used to be...(238-245).

The movement of patients through to lower levels of security in the service and in the community is constructed as a transfer of risk that requires expertise in managing it across the varying contexts. The potential shift in the operation of technologies of power on the patient in terms of restrictions and surveillance is made problematic in terms of her (psychiatrist's) experience of anxiety; highlighting a tension whereby risk and responsibility is seemingly '*handed over*' and yet the psychiatrist's subjective experience is still one of anxiety and a sense of responsibility for the patients actions. Again this notion of handing over an understanding of risk and the concern and responsibility associated with it is described here as the journey that professionals and patients are on.

Extract: 29

08MClinPsy:...we hold this discourse around risk we know everything there is to know and we describe something and we give it to someone else and we say this is what we want and I guess it's about finding different approach at different times and eventually its ultimately about handing over this this concern, this responsibility, that's the sort of journey we're on [yeah] they start off where everything is outside of their control, being arrested or being detained, going to court, and ultimately it's about whatever we do is handing it over because at some point without fail they will have more responsibility for everything, for their life, for their risk or harm to others for the risk to self-harm than they had before and in most cases actually having all the responsibility because they live on their own in the community and have to deal with life like everyone else and but it's being aware of that process I think... (301-311).

Despite the acknowledgement of the inherent uncertainties and implications for meaningful insights into patient's associated risks and the conceptualization of such things as discursively constructed, here risk is constructed as something to take responsibility for, and this responsibility needs to shift from the realm of the professional and institution to the patient. Ideas of technologies of self are drawn upon whereby the construction of moral subjects through '*conduct of conduct*' that will rationally assess their life choices through individual free will in such a way that responsibility for those actions is located in them and they will '*have to deal with life like everyone else*'. He goes on to suggest that people will be at different stages of this process, and consequently argues that professionals should be attuned to this to enable considered negotiation of when and how responsibility should fluidly shift between them and the patient. This is a process that echoes a concept of neoliberalism; to encourage individuals to give their lives an entrepreneurial form, as something they need to continually work on (McNay, 2009).

This process is reflected on in the following extract by this psychiatrist. He describes a patient who can articulate and produce a narrative of risk and

responsibility in relation to himself as someone who is positioned as desirable as opposed to someone who has *'always denied his index offence and there is overwhelming evidence against him who always denies that he's being mentally unwell but he's very compliant, very passive, takes his medication and has you know so he's not taking any ownership of the risk that he poses'* (286-288) despite the acknowledged and inherent uncertainties of taking this at *'face value'*.

Extract: 30

01MConPsy:...he's able to accept that he was unwell at the time, he's able to think about what the significance of the offence was, the function of the offence, how what the circumstances were, what the context was, you know what are the likely symptoms of relapse would like um and is you know able to construct a community management plan for themselves now that's a very different set up to the other man and you know there is a risk that you take somebody like the second man I'm talking about completely at face value and obviously people change once they are in the community [right] I mean people are not stupid by and large they understand what it is that treating teams and mental health review tribunals look for [yeah] but that being said, it's a much better position than the first man(303-312).

The patient who can produce such a view through the act of speech is accessing power by aligning themselves to a privileged discourse about risk. The complexity of how a patient might engage in such a process, in an institutional context that has multiple and potentially competing agendas for professionals and patients, is inevitably difficult to decipher but the capacity for this act meets the needs of professionals and patients alike and is produced as a *'much better position'*.

Before concluding the analysis chapter, I would like to acknowledge the voices of those who were somewhat absent. The social therapists whom I interviewed were noticeably absent from the discursive sites described above. I will provide an exploration of possible explanations for the absence of their voices. Firstly, social therapists are generally younger staff members who occupy a ward based role alongside nursing staff and could be considered as occupying a position on the

periphery of staff power dynamics. My analysis perhaps replicated these power dynamics by attending more to the voices of participants in professional roles with more power within the system. Secondly, social therapists tended to construct risk in terms of day to day contact with patients on the ward rather than the arguably more abstract discursive spaces described above by the other professionals. This is perhaps illustrated by this social therapist:

Extract: 31

09MST...being part for example and emergency nursing team or being a security nurse and all these roles you are there to solve the situation which might include de-escalation, verbal de-escalation, or restraint, seclusion, and these forms of physical intervention [yeah] so I think that the concept of risk in that context acquires a different quality because it's something that is part of your more than someone that come to the ward like only for a couple of hours a week and just listen to the narratives of risk from someone else basically (253-259).

Here the participant constructs risk as distinctly different for ward-based staff given the physicality of their involvement in potentially violent situations with patients. The separation between ward based staff was alluded to in a description by this social therapist and his curiosity in how sometimes nursing staff were considered part of the MDT (multi-disciplinary team) and sometimes they were categorized as sitting outside of it; *sometimes we refer to the MDT as if it's something external to us as if nursing is not part of the MDT...* (224-225).

Thirdly, my own background in psychology perhaps impacted on my analysis of the data and I was drawn towards particular constructions of risk that were compatible with my own understanding and conceptualization of the topic given my professional training, thus I aligned myself with professionals that I would regularly work with in my role as a clinician within a multi-disciplinary context.

Despite this, the tension between the MDT staff and the nursing team was reflected on and constructed by both social therapists that I interviewed.

Extract 32:

06FST: I know talking from a nursing perspective we often feel like our voice isn't heard because ultimately it's our decision when someone is put in seclusion because we are the first response basically [yeah] but it's not always our decision when someone is taken out because when the consultant comes to review doing the medical review, he may think that the patient is ready for example our guy who has been in seclusion a long time he might want to bring him out but we feel, we don't feel safe' (:219-224).

Conversely, this tension is also constructed from the point of view of this psychologist who reflects on the difficulty in encouraging nursing staff who are acknowledged to be more physically at risk from patients, to be involved in risk assessments;

Extract 33:

07FClinPsy: I have to update the risk assessments and I think it's very hard to get people on board with them you know, to contribute to them ... you don't want to come across as unsympathetic to what people have to be going through [yeah] and what they are on the receiving end of [yeah] but then it's trying to get them to think about well you know not to be drawn into knee jerk responses as well about things so I think that is the biggest challenge (416-423).

CHAPTER FOUR – SUMMARY, EVALUATION, AND IMPLICATIONS

This chapter will revisit the research questions and provide a summary of the main analytic points that address them. A critical evaluation of the research will be outlined as well as implications for future research and contributions to clinical practice.

4.1 RESEARCH QUESTIONS AND AIMS REVISITED

The aim of this project was to explore how mental health professionals working in a low and medium secure forensic service construct the concept of risk.

A critical review of the literature illustrated how clinicians have been positioned in relation to the concept of risk, particularly those working in a forensic context. The questionable value of a clinician's judgement in assessing dangerousness together with an increasing demand for their role in such matters, contributed to an inherent tension in this task. The emergence of the concept of risk was framed as a more empirically sound measure that could be quantified in more specific and probabilistic terms. Risk assessment was understood as a more objective and transparent process that might reduce unnecessary detainment of individuals by expanding the scope of the assessment, beyond that of the analysis of the individual. Risk thinking did not locate danger within an individual. However, it became paradoxical in that it blurred the distinction between the dangerous and the not dangerous by conceptualising risk on a continuum, while simultaneously being used as a clinical strategy to identify individuals as '*risky*'. The surge in the development of risk assessment tools that sought to turn away from a dichotomy of either dangerous or not has produced a wealth of risk knowledge and expertise. This has contributed to the notion that every misfortune can be turned into a risk that is potentially preventable and that someone should therefore be held culpable, reinforcing the unattainable idea of a decision and indeed a world without risk (Rose, 1998b).

The academic literature has seen a proliferation in risk assessment tools that aim to guide clinicians in the task of assessing risk of future violence and managing patients with mental health diagnoses who have committed acts of violence. The

majority of research is positioned from a realist epistemological position whereby concepts are accepted and represented at face value and consequently measured as such. Given the complexity and constructed nature of the concept, such an approach can be limiting. There is also minimal research on a clinician's perspective.

Therefore, this study aimed to take a different approach by speaking to clinicians directly in an open and unstructured format in an attempt to understand the complexity of their work and how they come to conceptualise risk in their practice. It was hoped that adopting a qualitative social constructionist approach would open up and allow the exploration of broader social and cultural issues that impact on clinical activity that are not captured by research taking a realist epistemological position.

As a consequence the primary research questions asked of the data were:

- What is being constructed as risk and what is being problematized?
- What technologies of power and self are being deployed in these constructions?
- What subject positions and social practices are made possible from these constructions?

The role and task of a clinician has become both one of therapeutic endeavours and of risk management. The richness and diversity of the content was striking and perhaps unsurprising given the often ill-defined nature of the concept of risk as illustrated in the review of the literature. Amongst the complexity and variety in the data, three interconnecting discursive sites were formed and presented which addressed the main research questions.

The first of these was, 'constructing the system as an inhibitor to meaningful information about patients and risk'. Professionals problematized the institutional setting within which they worked as something that amplified the distinction between professionals and patients and inhibited their capacity to discern

patients' subjective experiences and the associated risk with their conduct. The distinctiveness of the institutional context was elucidated through the accounts that positioned the service as an intersection of health and judicial frameworks. The inherent tension was problematized whereby professional practices and patient subjectivities were positioned in a binary manner; carer or custodian, patient on paper or patient in person, perhaps in reaction to the tension and complexity of the context. The institutions' distinctness from society, the community, or the real world served as a way to problematize its impact on meaningful assessments of risk. The relational experience between patients and professionals within the institution was reflected on in different ways. Including, professional practices that served to '*other*' the patients to the justification of the services' status quo in terms of the fluidity of restrictions (movement of bodies through levels of security) imposed on patients, given the institutions propensity to suppress and obscure professional insight into the internal experiences of patients. In terms of the distinctiveness of the institution, the position of therapy and therapeutic value in a forensic setting was made problematic whereby patients and professionals were positioned in a double bind, namely that patients are encouraged to '*face the pain*' of their offending but are also discouraged from such work when their experiences and behaviour are then labelled as '*risky*'. Such a system of competing agendas potentially hindered meaningful and candid assessments of risk.

Risk as something that was obscured and inhibited was also demonstrated in the second discursive site, 'the construction of risk to professionals through surveillance and accountability'. The enactment of disciplinary power and governmentality on not only patients but also on professionals was depicted in the problematization of the notions of accountability and bureaucracy. The direct and indirect surveillance of professional conduct from recordkeeping guidelines to public inquiries was constructed as ever-present and as influencing the clinical work of professionals and their management of perceived patient risks. Bureaucracy and accountability as a means to govern the activity of professionals was suggestive in some instances of eroding professional identities and capabilities, contributing to a system of regulatory practices that served to primarily secure the vulnerability a professional felt at the hands of the institution

rather than advance clinical activity. Such technologies of power made certain practices possible, from professionals engaging in the surveillance of their own activity which impacted on team discussions, decisions, and recommendations to the enactment of certain practices through the use of mental health legislation. The pressure of mental health professionals being positioned within a blame culture has been raised elsewhere (Rose, 1998b) particularly in relation to psychiatrists in the UK in which an examination of a college survey reported that 'while professional accountability is rightfully central to any psychiatrist's practice, the effects of this culture appear to be counterproductive, leading to defensive practice, and undermining both professional morale and recruitment into the profession'(Royal College Psychiatrists, 2008:21).

The notion of risk being obscured as described above was perhaps in contrast to the third discursive site, 'the construction of risk in relation to responsibility and as something that can be transferred'. Here the concept of risk is problematized in a manner that illuminates its presence and consequently the ability to transfer it and its associated responsibility between individuals and spaces within institutions and regulatory bodies. Risk is constructed as something that needs to be accepted by an individual patient and other community agencies in an increasingly dispersed gaze of institutions whose role is to measure, communicate, and manage factors that might be associated with an increased likelihood of undesirable conduct. Technologies of the self are drawn on whereby the institution and the professionals embark on a process of producing a self-disciplining subject in their patients who moves from a situation in which '*everything is outside of their control*' to taking more responsibility for their life and '*risk of harm to others*'. While the complexity and variations in how such a task can be performed and assessed, and the practices warranted is attended to by professionals, patient narratives indicative of taking up such a position of responsibility and self-discipline are positioned as most desirable.

4.2 EVALUATION AND CRITICAL REVIEW

Qualitative research requires active engagement in the data and is concerned with meaning as it is produced in a given context. It acknowledges an element of subjectivity in terms of the role of the researcher and the research process and

consequently the criteria that are traditionally used to evaluate quantitative studies (e.g. reliability, validity, generalizability) are not meaningful when applied to qualitative research (Willig, 2001). The position adopted by this research is different to the majority of quantitative studies taking a realist epistemological approach on this topic and as such should not be evaluated in the same way. The epistemological position underpinning qualitative research should be compatible with how it is evaluated, taking into account the assumptions of the position; what kind of knowledge the analysis aims to produce, what kinds of assumptions does the analysis makes about the world, and how does the analysis understands and conceptualises the role of the researcher in the research process (Willig, 2001). The FDA presented in this study will be evaluated against some recommended criteria from Henwood and Pidgeon (1992) and Elliot, Fischer, and Rennie (1999) as cited by Willig (2001) with particular reference to how I have grounded my observations within the context that they were generated, its internal coherence, and reflexivity.

4.2.1 Documentation and Coherence

The importance that the analytic categories fit the data well is considered a reasonable criterion on which to evaluate this type of research. A key way to demonstrate this is through explicit and clear documentation of the research process. As outlined in section 2.4.2.5 I provided a clear description of the stages of analysis in which I moved through the data from a micro level of analysis of each transcript, to broader analytical categories, then cross referencing and evidencing these categories and illustrated the final discursive sites with a detailed analysis of the selected extracts. Long extracts were included to improve the possibility for evaluation by the reader on the way I have interpreted and analysed the data.

The coherence of the analysis and the integration of theory are also reasonable criteria against which to consider the quality of qualitative research. While the three discursive sites identified are distinct in some ways, I understood there to be overlapping issues and factors amongst them and I have tried to write the analysis in a narrative that illustrates this. The process that went into categorising and identifying the underlying framework of the data set was labour intensive,

whereby I constantly moved in and out of a micro and macro analytical lens. The experience of writing up the analysis was a feeling of ease, the narrative flowed and the links between extracts and discursive constructions was well established in my thinking, perhaps in part to my efforts in determining an integrated and coherent framework beforehand that took account of the nuances in the data.

4.2.2 Reflexivity

Given that the approach of FDA assumes that all forms of knowledge are constructed through discursive practices and discourses, a researcher's report such as this is also considered a discursive construction (Willig, 2001). As a consequence reflexivity or a reflexive awareness of the problematic status of my own claims to knowledge is an important element in the research process.

Arguably qualitative researchers should be clear about their aims and research tasks whether they be general and exploratory or specific and more comprehensive. Given the paucity of qualitative research on this topic, my approach was one that aimed for a more general understanding of the phenomena. However, with hindsight given the identification of the discursive site, 'the construction of risk to professionals through surveillance and accountability' and some commentary in the literature on the impact of accountability, and public inquiries on clinical practice (Szmukler, 2000), a more specific and focused research question on this could have proved useful. The task of negotiating the vast amount of diverse data while attending to both the data set as a whole and to specific areas of interest was a difficult process; however I managed this through thorough and repeated examination of the data over time through an iterative process.

In chapter three I have reflected on the how the analytical process may have silenced the voices of some participants and I have provided possible explanations for this. It is important to highlight and draw attention to this absence and in doing so I hope that this gives these voices more consideration.

4.2.3 Strengths and Limitations of FDA

An approach employing Foucauldian concepts such as these enabled me to take a material discursive approach to look at the relationship between people's talk about risk and the social action associated with this. Such an approach enabled me to locate this 'risk' talk in a broader social and political context, something that prior research which has been predominantly quantitative has been unable to attend to. There are certain things that this type of approach did not enable me to do. A primary limitation cited is the lack of theorising of subjectivity in an approach such as this (McNay, 1992). An in depth analysis of the subjective experience of occupying a particular position e.g. 'being risky' or 'at risk' is not attended to. The lived experience of occupying a subject position is not examined nor is the potential agency of individuals in taking up such positions. As with all qualitative methods, they are not generalizable to other contexts and samples and in this instance the method was intended to provide an exploratory examination of the data. In an effort to address specific questions about policy and practice reforms mixed method approaches are recommended. Topics for further examination are highlighted in the following section on implications for future research and clinical practice.

4.3 IMPLICATIONS

4.3.1 Implications for future research

Given the predominance of quantitative research, further qualitative research in this area would be useful to focus on the meaning of risk language rather than describing it in quantifiable terms. As a consequence of the limited amount of qualitative research a broad based exploratory approach was taken in this study, further research with a narrower focus would be welcome.

There is an absence of relational factors such as the professional/patient relationship and the forensic institutional context within which these relationships are located, in traditional risk assessment measures and clinical interviews. A fuller understanding of how the institution acts as an inhibitor for professionals to knowingly assess their patients and professional attempts to resist or explore this with their patients is an important area for future exploration as this is the context within which such risk assessments take place.

Research in other contexts in which understandings of risk are discussed and constructed would illustrate the production of other and potentially different risk constructions. The intersection of the health and judicial institutions as unique to forensic work was highlighted in the interviews I conducted, and it was regularly implicated in the complexity of clinical activity and assessing risk. The tribunal process is a key space where these institutions intersect, an analysis involving key players to locate how risk is constructed in this particular context and the implications for these constructions on the positions taken up by individual stakeholders would be an interesting and useful pursuit given the implications of decisions made within this context. Policy development and documents are also central to how risk is understood and conceptualised, a historical analysis of key documents such as a genealogy would develop an understanding how the concept has evolved.

An examination of the relationship between ward staff and other members of the MDT would potentially illuminate any difficulties or barriers that influence the assessment of risk. Given the varying constructions, the implied disconnect between the nursing role and the MDT, and the reduced focus on this in this analysis a more focused enquiry is warranted.

As referred to in section 4.2.3 while I did not explicitly ask the mental health professionals about the risk they felt to their professionalism in the form of enquiries or accountability, it was something to which they frequently referred to. A more focused research question on how accountability and risk assessment impact on each other and how mental health professionals negotiate this would potentially produce richer or different data than this study was able to provide.

4.3.2 Implications for clinical practice

4.3.2.1 Supervision and reflexive practice

Supervision and the engagement of reflexive practice are key elements in the professional and ethical conduct of clinical psychologists, whereby they are expected to receive supervision themselves and provide it to others (British Psychological Society, 2003; 2006). The provision of space to enable the

consideration of the above issues would raise professionals' awareness of how they are subject to processes of power. Explicitly engaging with ideas such as how the institution is implicated in the production of risk knowledge and practices would enable professionals to consider how they are positioned within the institution and to consider what role they should have in negotiating this. Openly acknowledging and discussing the professional dilemmas encountered by the enactment of disciplinary power on professional practice through bureaucracy and notions of accountability could open up more thoughtful and transparent responses. Supervision on how to manage the institutions intolerance to what some might argue is necessary for therapeutic progress could also be helpful.

4.3.2.2 Short term toleration of risk

The construction of risk and its tension with therapeutic initiatives and the potential creation of a double bind situation is something worth considering by practicing clinicians. The apparent intolerance of forensic services of certain types of behaviour or patient experiences at the potential expense of therapeutic progress suggests that services might be improved if they could tolerate what is perceived to be an increase in immediate risk (as a result of painful therapeutic work) to promote potentially more meaningful assessments, that are less obscured by the disciplinary practices of the institution. Consideration of service policy and the implementation of practices to support such an initiative would be required and could include the provision of non-blaming reflective spaces for staff aimed at increasing understanding among the team of the broader context of both patients and staff interactions. Taking a more systemic approach might enable more consideration and discussion of the complexity of people's experience in a manner that is less threatening and non-blaming to individual staff members. The literature on offence paralleling behaviour (Daffern, Jones, & Shine, 2010) could be used to incorporate the influence of the institution itself in the assessments of patient risks. More of an emphasis on the assessment of the psychological functions of violence and a focus on intervention on the modification of behavioural patterns that parallel violence with respect to its function (Daffern, Jones, & Shine, 2010) could prove valuable. The development of service policy that puts this and other formulation informed theories of violence (Sturmey & McMurrin, 2011) as central to service provision might reduce

reactive interventions that potentially reduce the complexity of patient behaviour and instead enable more thoughtful and meaningful assessments. The short term toleration of risk might also include positive risk taking, allowing patients the agency and autonomy necessary to move forward in their recovery. If appropriately supported, the engagement in new experiences and challenges can promote the resilience and coping skills required by patients. The complexity of such a task within an institution in which professional anxiety about risk is understandably increased is not overlooked, proponents of such an approach suggest that 'if recovery as a set of values is ever to have parity with risk reduction in secure services then there has to be clarity at an organisational level about how the complexities that arise from the two are handled' (Barker, 2012:38). Such an approach is arguably more consistent with a tailored and relational understanding of patients in line with the recovery agenda (Shephard, Boardman, & Slade, 2008).

4.3.2.3 Recovery and risk

The notion of recovery as something that is individual and not something that services can do to a person but rather play a contributory and supportive role in, has been a recent driver in mental health practice and policy. A full examination of the philosophy underpinning this approach is not possible here and can be found elsewhere (Slade, 2009a). While it is a contested term, a widely used definition of recovery is '*a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness*' (Anthony, 1993:15). Such ideas have found support in some policy documents e.g. *The Expert Patient* (Department of Health, 2001) and *Our Health, Our Care, Our Say* (Department of Health, 2006) and the difficulties and barriers to how such a notion can be implemented and practiced in clinical settings are being examined (Shephard, Boardman, & Slade, 2008; Slade, 2009b). How recovery relates to secure settings has recently been explored (Drennan & Alred, 2012) and further examination and development of policy on how these ideas fit within a forensic service dominated by risk processes and clinical recovery (reduction in

symptoms) is warranted. Advocates of a recovery focus in secure settings conceptualise recovery as the overarching goal of the service with 'offender recovery' as being a distinct part of this rather than something separate delineated as risk that is more important than a patient's progress or recovery (Barker, 2012). Such an approach suggests collaborative and transparent risk assessment processes with patients, assisting patients to envision a satisfying offender free life, the incorporation of strength based assessments (e.g. SAPROF), and models that focus on the function of offender behaviour e.g. The Good Lives Model (Ward, 2002; Ward & Maruna, 2007). The complexity faced by clinical teams in how to relieve some control to allow a shift in institutional responsibility of risk to personal responsibility and personal recovery is in the timing of its introduction to the patient; too early and you risk overwhelming and alienating them and too late it risks being tokenistic. How the obligations and restrictions placed on patients within a forensic service connect to a more loosely and self-defined notion of recovery in terms of risk, people's prior offending, and personal responsibility, requires considerable development from policy makers. Other policy initiatives could include the practice of counter-inquiries as opposed to only homicide inquiries to provide information on clinical practice deemed to have had a positive outcome.

4.3.2.4 Counter-inquiries

The construction of risk in terms of professional accountability and notions of blame in a climate of inquiry was striking in terms of how this impacted on professional practice.). A strategy to resist this might be the introduction of more solution focused counter-inquiries that aim to look at clinical cases in detail that are deemed to have had a positive outcome rather than a negative one. Such a practice might serve to counter the blame and hostility encountered by professionals in light of the current practice of only conducting homicide inquiries. Such an approach could limit the bias inherent in only examining worse case scenarios (Schmukler, 2000) and provide richer insights and learning for mental health professionals by providing information on clinical practice associated with positive outcomes. It might resist and open up more positions for professionals to occupy in relation to risk and limit the occupation of a defensive position by

promoting a less blaming culture for mental health professionals in the spirit of action research and appreciative inquiry (Cooperrider & Srivastva, 1987).

4.4 A FINAL THOUGHT

This study has attempted to examine *'the behemoth of risk which means nothing and means everything for people'* (08MClinPsy:229) to illustrate the powerfulness of risk discourses for patients and professionals without reducing the complexity to a 'number' or 'expertise'. It is hoped that my shift away from a realist perspective has provided insights into the broader social, relational, and institutional power relations that locates professionals and patients in particular subject positions and that influence and produce risk. Such insights should serve to influence more thoughtful responses and assessments by clinicians who can recognise and reflect on their own position and institutional context in influencing the conceptualisation of patient risk.

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Appendix 1: University of East London Ethical Approval

ETHICAL PRACTICE CHECKLIST (Professional Doctorates)

SUPERVISOR: Pippa Dell

ASSESSOR: Mary Spiller

STUDENT: Anna Woodall

DATE (sent to assessor): 28/02/2013

Proposed research topic: How do mental health professionals working in a low and medium secure forensic service construct the meaning of 'risk'?

Course: Prof Doc Clinical Psychology

- | | |
|--|------|
| 1. Will free and informed consent of participants be obtained? | YES |
| 2. If there is any deception is it justified? | N/A |
| 3. Will information obtained remain confidential? | YES |
| 4. Will participants be made aware of their right to withdraw at any time? | YES |
| 5. Will participants be adequately debriefed? | YES |
| 6. If this study involves observation does it respect participants' privacy? | NA |
| 7. If the proposal involves participants whose free and informed consent may be in question (e.g. for reasons of age, mental or emotional incapacity), are they treated ethically? | / NA |
| 8. Is procedure that might cause distress to participants ethical? | NA |
| 9. If there are inducements to take part in the project is this ethical? | NA |
| 10. If there are any other ethical issues involved, are they a problem? | NA |

APPROVED

YES		
-----	--	--

MINOR CONDITIONS:

REASONS FOR NON APPROVAL:

Assessor initials: MS

Date: 28.02.13

RESEARCHER RISK ASSESSMENT CHECKLIST (BSc/MSc/MA)

SUPERVISOR: Pippa Dell

ASSESSOR: Mary Spiller

STUDENT: Anna Woodall

DATE (sent to assessor): 28/02/2013

Proposed research topic: How do mental health professionals working in a low and medium secure forensic service construct the meaning of 'risk'?

Course: Prof Doc Clinical Psychology

Would the proposed project expose the researcher to any of the following kinds of hazard?

- | | | |
|----|--|----|
| 1 | Emotional | NO |
| 2. | Physical | NO |
| 3. | Other
(e.g. health & safety issues) | NO |

If you've answered YES to any of the above please estimate the chance of the researcher being harmed as: HIGH / MED / LOW

APPROVED

YES		
-----	--	--

MINOR CONDITIONS:

REASONS FOR NON APPROVAL:

Assessor initials: **MS** Date: 28.02.13

For the attention of the assessor: Please return the completed checklists by e-mail to ethics.applications@uel.ac.uk within 1 week.

SCHOOL OF PSYCHOLOGY

Dean: Professor Mark N. O. Davies, PhD, CPsychol, CBiol.



School of Psychology Professional Doctorate Programmes

To Whom It May Concern:

This is to confirm that the Professional Doctorate candidate named in the attached ethics approval is conducting research as part of the requirements of the Professional Doctorate programme on which he/she is enrolled.

The Research Ethics Committee of the School of Psychology, University of East London, has approved this candidate's research ethics application and he/she is therefore covered by the University's indemnity insurance policy while conducting the research. This policy should normally cover for any untoward event. The University does not offer 'no fault' cover, so in the event of an untoward occurrence leading to a claim against the institution, the claimant would be obliged to bring an action against the University and seek compensation through the courts.

As the candidate is a student of the University of East London, the University will act as the sponsor of his/her research. UEL will also fund expenses arising from the research, such as photocopying and postage.

Yours faithfully,

Dr. Mark Finn

Chair of the School of Psychology Ethics Sub-Committee

Stratford Campus, Water Lane, Stratford, London E15 4LZ
tel: +44 (0)20 8223 4966 fax: +44 (0)20 8223 4937
e-mail: mno.davies@uel.ac.uk web: www.uel.ac.uk/psychology



The University of East London has campuses at London Docklands and Stratford
If you have any special access or communication requirements for your visit, please let us know. MINICOM 020 8223 2853



Appendix 2: Research and Development Approval



NHS Foundation Trust

Joint Research Management Office

FINAL R&D APPROVAL

13 June 2013

Tel: 020 7882 7260

Fax: 020 7882 7776

Email: Sponsorrep@nhs.uk

Dear Mr. Mann,

Protocol: Mental Health professionals working in low and medium forensic services constructions of risk

ReDA Ref: AF1305/2

REC Ref: UEL review; no reference provided

I am pleased to inform you that the Joint Research Management Office for [redacted] NHS Trust and Queen Mary University of London has approved the above referenced study and in so doing has ensured that there is appropriate indemnity cover against any negligence that may occur during the course of your project, on behalf of [redacted]. Approved study documents are as follows:

Type	Version	Date
REC approval	UEL REC	28.02.2013
Protocol		13.12.2012
Participant Invitation Letter	v.1	15.05.2013
Consent Form	v.1	15.05.2013

Please note that all research within the NHS is subject to the Research Governance Framework for Health and Social Care, 2005. If you are unfamiliar with the standards contained in this document, or the BH and QMUL policies that reinforce them, you can obtain details from the Joint Research Management Office or go to:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4108962

You must stay in touch with the Joint Research Management Office during the course of the research project, in particular:

- If there is a change of Principal Investigator
- When the project finishes
- If amendments are made, whether substantial or non-substantial

This is necessary to ensure that your R&D Approval and indemnity cover remain valid. Should any Serious Adverse Events (SAEs) or untoward events occur it is **essential** that you inform the Sponsor within 24 hours. If patients or staff are involved in an incident, you should also follow the Trust Adverse Incident reporting procedure or contact the Risk Management Unit on 020 7480 4718.

We wish you all the best with your research, and if you need any help or assistance during its course, please do not hesitate to contact the Office.

Yours sincerely



0 [REDACTED] Head of Research Resources

Copy to: Sponsor – Anna Woodall (CI)

1 [REDACTED]

Page 2 of 2

Appendix 3: Participant Information Sheet

PARTICIPANT INVITATION LETTER

UNIVERSITY OF EAST LONDON

School of Psychology
Stratford Campus
Water Lane
London E15 4LZ

The Principal Investigator

Anna Woodall
Contact Details: XXX@uel.ac.uk

Consent to Participate in a Research Study

The purpose of this letter is to provide you with the information that you need to consider when deciding to participate in this research study. The study is being conducted as part of my Doctorate in Clinical Psychology degree at the University of East London.

Project Title

Mental health professionals working in low and medium forensic services constructions of risk.

Project Description

The aim of the study is to explore how mental health professionals conceptualise risk and what the implications of these constructions might have on clinical practice. Participants in the study will be asked to discuss this topic in the form of a conversational interview with myself. Interviews will last for 40-60 minutes.

Confidentiality of the Data

Names and contact details of participants will be kept in a safe place which only I have access to.

Data will be treated confidentially by changing all names and identifying references in the transcriptions of interviews.

My supervisor and examiners will only read extracts from the anonymised transcriptions of the interviews.

At the completion of this study all audio recordings will be destroyed. The research may be developed at a later stage for publication therefore electronic copies of anonymised transcripts will be kept.

Location

Interviews will be held at your place of work.

Disclaimer

You are not obliged to take part in this study and should not feel coerced. You are free to withdraw at any time. Should you choose to withdraw from the study you may do so without disadvantage to yourself and without any obligation to give a reason

Please feel free to ask me any questions. If you are happy to continue you will be asked to sign a consent form prior to your participation. Please retain this invitation letter for reference.

If you have any questions or concerns about how the study has been conducted, please contact the study's supervisor, Dr Pippa Dell, School of Psychology, University of East London, Water Lane, London E15 4LZ. Email address: P.A.Dell@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr. Mark Finn, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Tel: 020 8223 4493. Email: m.finn@uel.ac.uk)

Thank you in anticipation.
Yours sincerely,
Anna Woodall

Appendix 4: Participant Consent Form

CONSENT FORM

UNIVERSITY OF EAST LONDON

Consent to participate in a research study

Mental health professionals working in low and medium forensic services constructions of risk.

I have read the information sheet relating to the above research study and have been given a copy to keep. The nature and purpose of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason.

Participant's Name (BLOCK CAPITALS)

.....

Participant's Signature

.....

Researcher's Name (BLOCK CAPITALS)

.....

Researcher's Signature

.....

Date:

Appendix 5: Interview Strategies

Informed consent – check at start they have read consent form, halfway through interview summarise what's been said and ask for consent to continue, at the end of the interview summarise what's been said, what will happen to the data and if they are still happy to consent.

Is it ok to take notes 'verbatim' as I don't want to interrupt you, and I may come back to something you've mentioned?

Ask them to give a short biography of themselves and why were they interested in coming to speak to me?

Co-agenda @ the beginning: these are my plans what would you like to include?

I would like to think about risk, perhaps in relation to:

Being in hospital, leave, discharge, and living in the community

The topics I want to cover are X Y and Z, If I mention X what comes to mind

Can you tell me more about X

What is your experience of X

What do you think of X

Can you tell me an example

Tell me more

When you said X, Can you tell me more about that

I'm thinking Y what do you think

Mirroring, repeating back.

Influences on how you think about risk

Has the way you think about risk changed throughout your career

More prompt questions when power issues come up...

Debrief: what's happening with the data – transcripts verbatim don't come out in neat sentences! You'll get a chance to see it with the option to withdraw. Be explicit about anonymity – have them pick a pseudonym.

Distress: Stop and acknowledge their distress, ask if they would like to stop and/or get them to consent to carry on.

Appendix 6:

Transcription Conventions

Notation	Example	Description
[pause]	No it's fine [pause]	Audible pause of more than two seconds.
<i>Italics</i>	<i>'London Suburb'</i>	Description of place, name or thing that has been anonymised.
[]	[hmm] [ok]	Used to indicate the interviewer's interjections within the speech of the interviewee.
[]	[laughter]	To indicate laughter of interviewer or interviewee.
...	you can have a dialogue about their... 01MConP: Yeah	To indicate overlapping speech between interviewer or interviewee.
[?]	[holding?]	To indicate a guess at what was said if it was difficult to decipher
[]	[inaudible]	Inaudible

Coding Key for Interview Transcripts

The number denotes the number of the interview (chronologically labelled in the order that they were conducted).

The first letter (M/F) denotes the gender of the participant.

The proceeding combination of letters denotes the profession of the participant:

ConP = Consultant Psychiatrist

SW = Social Worker

OT = Occupational Therapist

CPsythe = Consultant Psychotherapist

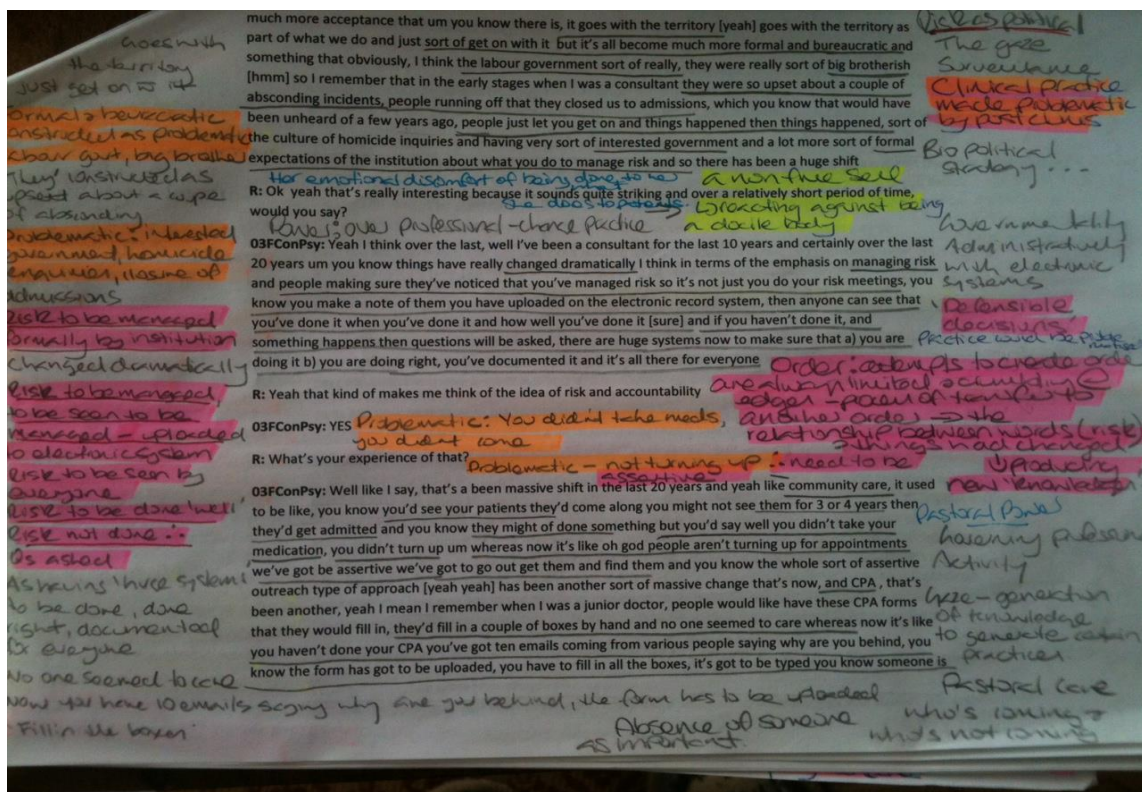
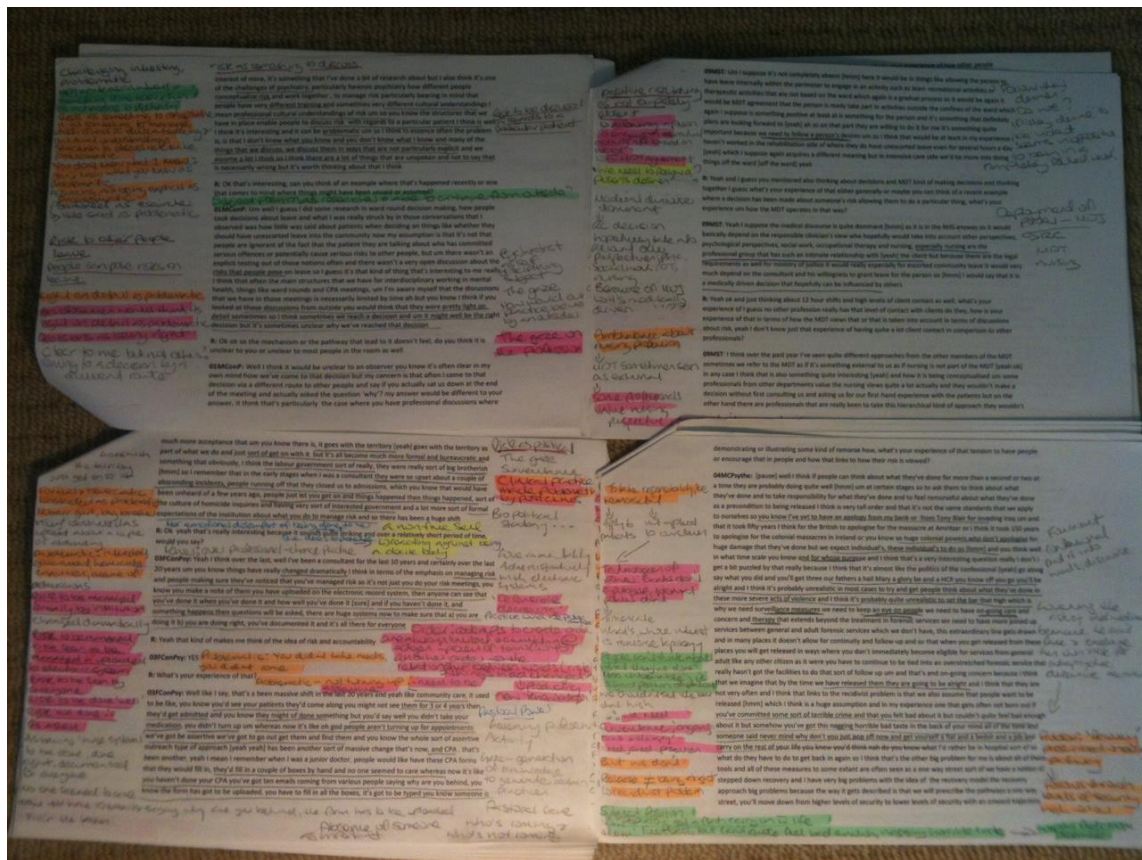
CNL = Clinical Nurse Leader

ClinPsy = Clinical Psychologist

ST = Social Therapist (psychology graduates in a ward based role)

E.g. 01MCP = Male Consultant Psychiatrist

Appendix 7: Visual representation of the coding of transcripts



Appendix 8: Example of extracts categorised into one of the initial themes

Risk Averse

finding a balance sometimes it quite hard so either people can be risk averse, very risk averse and kind of interrupt everything as risky just because you know people aren't allowed to have a wobbly day or kind of reading too much into things and not thinking about that particular person's individual formulation losing sight of that, a bit um or it kind of goes the other way not thinking enough about risk [yeah] being a bit sort of drawn in and a bit blasé a bit desensitised with whatever [yeah ok] and it is you know it is difficult to keep all those things in mind

] inappropriate ways on the ward or there is some whether that necessarily means they, that that there is a risk of them, there is any sort of risk of being kind of um out in the community whether that will still be the case whether they will display those same behaviours in different contexts, out in the community so those sort of that often an assumption is made which you think that's not the case that might become too risk averse and being quite um restrictive you can actually, that can be very counter-productive ...I've heard people say well I'm not, I don't want to sign, put my name on the paper work, I didn't, I wasn't sure, you know anything can happen and it's not really yeah so just not feeling comfortable um in making those decisions and perhaps feeling quite overwhelmed really by things

you kind of get some sense of what you do whether it makes a difference rightly or wrongly um of course that's not perfect is it because there is a tendency then to nullify risk and to act in a way that is much more risk averse and then you think you are saving the world but actually you're not you are just imposing unnecessary restrictions on people

I've been subject to an number of enquiries after things have gone wrong with my patients and that does that you've got to guard against that coloring your judgment and pushing you into a very risk averse position so you're thinking about risk assessment those factors are important because they potentially influence the decisions you make

A fantasy to get rid of risk, to have certainty like the locks and walls of this place.

Risk as a word that when said can shut down thinking.

therapeutic initiatives that can be stopped, can be sort of you know before they even exist, the idea it can be snuffed out if just someone says it's too risky or you know we have a risk assessment or someone makes therapeutic progress, risk can sort of counter-balance that um

Yes and now there is also sort of a mountain of bureaucracy all the time because with accountability comes paper and forms [yeah] and the job is just much more boring you know I mean inevitably there is less um you know you are more worried about stuff going wrong, a bit more defensive in the way you work and sort of a bit more stressed about have you got all the paperwork done all the time so it's not, it's not the job it used to be at all which is gutting

so that I tend to think that we hang on to people longer than we should because of a suspiciousness of prediction that they are going to do it again and missing the I think the fact that the world is full of dangerous people [hmm] and so the danger if it resides is not I think we miss a trick in psychiatry and we don't realise the extent to which we're dangerous and you know that we're disordered that we don't think straight, we abuse and mistreat people with our double standards and hypocrisies as well as straightforwardly and that bankers and politicians and all of society is far more dangerous than most of these guys but we don't do much about that and I think you know if we really were concerned with risk we'd ask very different questions [hmm] who's more dangerous

I think people are fearful of the repercussions, I think professionals always hold fear of the repercussions and you get some that are risk takers or willing to take positive risks and you get that just won't take any risks [yeah] and that becomes a struggle, a real struggle and to an extent its understandable because what we see in society is blame rests with individuals and I don't think any of us want to be sat with that sort of blame or that sort of experience um and you get some people that try and manage things a little bit manipulatively so the risk that doesn't sit with them but at the same time they take risks [ok] so Dr 'Smith' for example wouldn't necessarily discharge someone but he'll speak in a tribunal in a way that encourages discharge but he's not recommending that and he would say that openly so I'm not taking I'm not taking his name in vain [yeah] so the blame doesn't sit with him if it all goes pear shaped