Initial Assessment in Forensic Psychiatry: The Forensic Assessment Format as a boundary object

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The *Forensic Assessment Format* as a boundary object

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Abstract

This research project offers initial assessment in forensic psychiatry a new assessment guideline, the Forensic Assessment Format, (Carey 2006) which is a development from Jane Ussher's material-discursive-intrapsychic model of critical realism, (Ussher 2000a). It presents a review of the technical and theoretical literature looking at the development of assessment methods in forensic psychiatry and discusses current practice and how a critical realist perspective could inform the assessment process. It is a qualitative study using both an empirical and an analytic auto-ethnographic approaches, (Anderson 2006). The research project presents data from 19 semi-structured interviews and a focus group analysed using grounded theory, (Glaser and Strauss 1967) to aid both deductive and abductive approaches, (Timmermans and Tavory 2012). Service users were involved from the beginning of the project to inform the themes that developed into the interview questions.

The outcomes of the study offer support for the potential of this critical method of initial assessment to be collaborative, holistic and inclusive and that it could act as a *boundary object*, (Star and Griesemer 1989), between different social worlds providing a bridge for information to flow. This encourages cooperation in completing the assessment and then formulating and meeting the identified needs. It explores and provides an insight into the initial assessment process in forensic psychiatry from the perspective of the service user, referrer and assessor. Further suggestions are offered in associated areas such as how plural realities can be understood and how the assessment process in forensic psychiatry could be further improved.

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Doctoral Thesis

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Dedication and Acknowledgement

“Una buona mamma vale cento maestre”

Italian saying

I dedicate this work to my late mother; Fernanda Maria Rinaldi who instilled in me a passion to find out what makes people tick.

I would like to thank my wife, Kim, for her support, encouragement, patience and belief that this project would eventually, at some point, be completed.

My main supervisor, Di Bailey who, from 2006 to 2010, encouraged and motivated me through the ethical and theoretical minefields of completing research in secure settings, and she deserves a special thank you.

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Chapter 1 Setting the Scene

"'Madness' is therefore always a product of the symbiotic relationship between material, discursive and intrapsychic factors; one level of analysis cannot be considered without the other."

(Ussher 2000a p221)

This thesis is about a new approach to assessment in forensic psychiatry. The minority of people who present as a risk to others in the context of compromised mental health, (Monahan 1992), deserve the opportunity to collaborate in a holistic assessment to meet their needs. That this process has been inconsistent and a new approach to assessment in forensic psychiatry is indicated will be suggested in this thesis. Initial assessment in forensic psychiatry should be a process that allows service users, referrers and assessing professionals to develop an understanding of the person being assessed as an individual and to appreciate their strengths, needs and risks in a collaborative, holistic and inclusive manner. Assessment could then lead to the formulation of an inter-disciplinary plan to meet those needs and enhance strengths with the aim of improving mental health and reducing levels of risk.

Jane Ussher offers us her epistemological explanation for the development of *madness*, and how it can be understood. To adapt her *material-discursive-intrapsychic* model into a method of assessment is to accept a different ontological explanation for each individual's reality. Initial assessment in forensic psychiatry is a process that describes the first contact between a service user and the assessing professional following a referral and looks to assess and identify both risk and need. This thesis will offer the *Forensic Assessment Format*, (FAF), (Carey 2006, 2008, Bailey 2012 pp161-164), as an initial assessment guideline for forensic psychiatry developed from Ussher's model. Following referral, the FAF allows the assessor to develop a better understanding of the service user as an individual and to appreciate their strengths, needs and risks in a collaborative, holistic and inclusive manner that leads to formulated outcomes.

This chapter will introduce the reader to the policy context that gave rise to forensic psychiatry before moving on to discuss the clinical context and the development of

assessment methods in forensic psychiatry. To give some understanding of the service users involved in the forensic psychiatry community service at the centre of the research project, the descriptive database covering five years of referrals will be used to present a picture of the people assessed. The concept of developing the FAF into a *boundary object* (Star and Griesemer 1989) acting as a bridge between different social worlds will also be introduced.

1.1 Introduction to the policy context in forensic psychiatry.

Over the last three decades in England and Wales, mental health services have been subject to two major developments; firstly, an increased focus on the assessment and management of risk and secondly, the rise of service user involvement in planning mental health services and individual care packages. The focus on managing risk can be conceptualised with the introduction of the *Care Programme Approach*, (Department of Health 1990) which sought to formalise the process of assessing a service users' needs within a regular multidisciplinary review process. Initial results of the CPA process were not positive and Rose found that few service users were aware of the way their care was coordinated or felt involved in it, (Rose 2003). Crawford et al, (2003), found that although service users and providers of mental health services could see some positive changes, responsiveness of staff and representativeness of service users may be impeding the process. CPA is now an integrated part of mental health care in England and Wales and is designed to ensure regular review of service user needs.

The management and care of *restricted* forensic patients, i.e. those on Section 41 or 49 of part three of the *Mental Health Act 1983*, (Department of Health 2008) was more effectively assessed by the issuing of a checklist by the Home Office of points they will consider when examining cases of restricted patients, (Dent 1997). The ethical considerations noted by the Home Office, are highlighted by their stated aim to '*secure individuals' rights and freedoms under the law',* (Dent 1997 p265), whilst remaining aware of the need to protect the public from serious harm. This dual approach of care and custody when working with mentally disordered offenders

needs careful consideration of the ethical implications of assessment and intervention by forensic psychiatric services.

The need to assess mentally disordered offenders, (MDO's), in a comprehensive manner to gain an understanding of their needs, is a development from the report by John Reed, (Department of Health and The Home Office 1992), which established the need for MDO's to be dealt with by health and social services and not just the criminal justice system. The double stigma of being seen by society as both mentally ill, and an offender, '*a double deviant*', (Pilgrim and Rogers 1999 p167), increases its perception of risk towards MDO's, (Corrigan and Penn 1999). The role of health professionals may be compromised ethically, if they over state risk factors due to poor assessment of mental health, (Peay 2000) or overemphasise clinical presentation due to external influences, such as the media, pressure groups, or self-interest, (Barnes and Earnshaw 1993, Hammond 1996).

The involvement of service users was formalised in the *National Service Framework for Mental Health*, (NSF), informed by a working group chaired by Graham Thornicroft, (Department of Health 1999). The method of assessment suggested in this thesis will exceed these suggestions by using a theory from a critical realist perspective, the material-discursive-intrapsychic model put forward by Jane Ussher (Ussher 2000a) and adapted by the author into the Forensic Assessment Format, FAF, (Carey 2008, Bailey 2012 pp161-164).

In the report, *A first class service: Quality in the new NHS*, (Department of Health 1998), the National Institute of Clinical Excellence (NICE) was established as a method of setting national standards for the NHS. Methods of delivering these standards were also established through the implementation of Clinical Governance Systems as well as by establishing Lifelong Learning and Professional Self-Regulation for NHS Staff. These standards were monitored by the Commission for Health Improvement, A National Framework for Assessing Performance and the National Survey of Patient and User Experience. These developments came from the premise that *'all patients in the National Health Service are entitled to high quality care'*, (Department of Health 1998 p2). High quality care can only be delivered if the needs of service users are established through a comprehensive assessment

process. In Forensic Psychiatry[1], initial assessment is a process that has been variable and dependant on local processes, usually involving a symptom based approach or the use of psychometric tests. This thesis is looking to advise what works best in the assessment process in forensic psychiatry by offering a new approach and reporting on peoples experiences of the assessment process.

Service users are now more involved in service provision, such as training mental health staff using the co-production model of the *Knowledge and Understanding Framework* for personality disorder, (Personality Disorder Institute 2011) and they are also employed by Foundation Trusts to inform service provision. Moving these developments forward in the field of forensic psychiatry led the author to consider the Forensic Assessment Format as a method of engaging service users in a collaborative assessment process.

In writing this thesis, a decision had to be made on what terminology to use when referring to mentally disordered offenders. There are various options, including patient, service user and mentally disordered offender. The use of language is a powerful tool, and this is recognised in critical realism generally, (Bhaskar 1989), (Ussher 2000a). In deciding to use *service user* when referring to this group, this is with an awareness that this term is seen as having an influence in the modern NHS, with service user groups advising the hospitals and services that they use, (Stickley 2006), however this term does not give a linguistic balance against the unseen social forces that are the dominant discourse in psychiatry. Service users groups are rarely paid for their advice, which reflects the dominant groups feeling of superiority. However, an alternate is not available at present, and the term service user will be used when referring to patients or mentally disordered offenders.

Forensic psychiatry developed in the second part of the 20th century as a specialty within the psychiatric field. The word *forensic* developed in the United Kingdom in the mid-17th century from the Latin word *forensis* which translates as *'in open court, public'*, from the word *forum,* which, in an ancient Roman city was a public square or marketplace that was used for judicial and other business, (Oxford University Press 2015). The public interest in forensic psychiatry and its service users' remains evident in the popular press.

1.2 Introduction to the clinical context in forensic psychiatry

The process of initial assessment can take a matter of minutes or several months, depending on the particular circumstances. Having an interview schedule, or a list of questions, can help to give the process a level of thoroughness that will tease out the important points needed to assess the service users current needs and risks. To make this a more collaborative process, it is proposed that theories from a critical realist and social constructionist perspective should be utilised, moving the process on from one that a professional does to a service user, i.e. assess them; to a collaborative situation where the professional and the service user work together to discover the level of risk and need, and how best to meet them. To do this, it is proposed that a new assessment guideline should be considered, the Forensic Assessment Format, (Carey 2008), (Bailey 2012 pp161-164), which is used by the forensic Community Mental Health Team[2], (Forensic CMHT), at Ridgeway Forensic Service, (formally the Hutton Centre) in Middlesbrough. This research project set out to discover how service users, assessing staff and referrers experienced the initial assessment process using the Forensic Assessment Format, how they perceived the assessment process, contributed to it and agreed on a path forward. The development of the FAF into a *Boundary Object* that inhabits several intersecting social worlds whilst satisfying the information requirements of each of them, (Star and Griesemer 1989 p393), will be discussed at length in chapter 3.2.4.

Initial assessment in forensic psychiatry has become more focused on risk assessment and management using tools such as the *Historical and Clinical Risk Management 20, HCR20* (Webster, Douglas et al. 1997, Douglas, Hart et al. 2013) and the *Short Term Assessment of Risk and Treatability, START* (Nicholls, Brink et al. 2006). Kevin Douglas and Tonia Nichols work using actuarial tools to inform formulation using a structured professional judgement approach has led to more psychological methods being used in the assessment of people with mental health problems that come into contact with the criminal justice system. Caroline Logan suggests that a '*collaborative interview is more likely to ensure that the client's views and aspirations are represented...'* (Logan and Johnstone 2013 p289). Finding a balance between these two approaches is what is offered in this project. Using a critical approach to initial assessment that does not focus on risk per se, but

engages with the service user collaboratively to understand needs as well as risk to give a more holistic picture of the service user.

The assessment process in forensic psychiatry can be viewed from different perspectives dependant on your point of engagement. That could be as a service user, an assessor or as a referrer to an assessing service. From a service user's perspective, it can be an invasive situation at a time of high emotional pressure; or be equally seen as an opportunity to ventilate that emotional reaction, reducing its impact on mental health. From the assessor's viewpoint, it can be the way that a perspective can be encouraged to emerge from what can be a chaotic situation. A referrer will usually be looking for advice in managing risk.

As a member of a forensic community service, the author's perspective is that of an assessor, a role developed over the past three decades working as a forensic Community Psychiatric Nurse[3], (CPN). Using an analytic auto-ethnographic approach, (Anderson 2006) to gain some understanding of this process, it was planned to develop this understanding by interviewing the people involved in it.

> '*To understand personal meanings and subjective experiences one has to become involved with the lives of the subjects being studied. That is, some degree of empathy must develop between the researcher and the subject. By empathy we mean the ability to 'put ourselves in the other persons shoes' or to see things from their perspective(s). Reality is said to be constructed by the individual',*
>
> (Polgar and Thomas 2008 p86*)*.

This process has used an approach that will be detailed below, the Forensic Assessment Format; but it is the response to the interaction that may be most telling, rather than the opinion about one process or another. Is the assessment process a method of gaining a diagnosis, a history, a perspective, developing an understanding of risk, or is it a therapeutic intervention per se? *'Clinicians and patients make assessments and come to decisions about health care interventions at a particular time, based on what they know at that time*', (Griffiths, Borkan et al. 2010 p1631). The purpose of a clinical interview is to '*understand and then do something positive to address the needs identified*.', (Logan and Johnstone 2013 p259). Thus, Frances

Griffiths and Caroline Logan link the assessment of an individual's needs with doing something positive about meeting those needs.

From a clinical perspective, completing a forensic assessment is usually about creating a report to identify clinical needs and suggest ways of identifying and managing risk. From a referrer's perspective, it is usually about gaining a specialist opinion on a high risk service user to garner a confirmation that all is being done to manage risk and treat the individual. The service user will usually be in a crisis situation, and may perceive the forensic assessment team as something that could deny their liberty by signposting them towards incarceration, either in hospital or prison.

The hypothesis offered is that assessment can be an opportunity for plural realities to co-exist and be shared and understood. Phenomenology allows the concept of '*multiple realities'*, (Polgar and Thomas 2008 p84), in that people may experience the world in different ways. The perception of a court to a service user who has committed a serious offence is wrapped in the cloth of the legal process, which is one reality. The service user may view the same events as a valid response given the perspective they view it from; their viewpoint of that reality may be adjacent/ parallel/ obtuse or opposed to the perspective of others due to a variety of mental health conditions, but is it as valid? Picture three intersecting circles representing the service user, the referrer, and the assessor, with the 'truth' in the intersecting centre, figure 1.

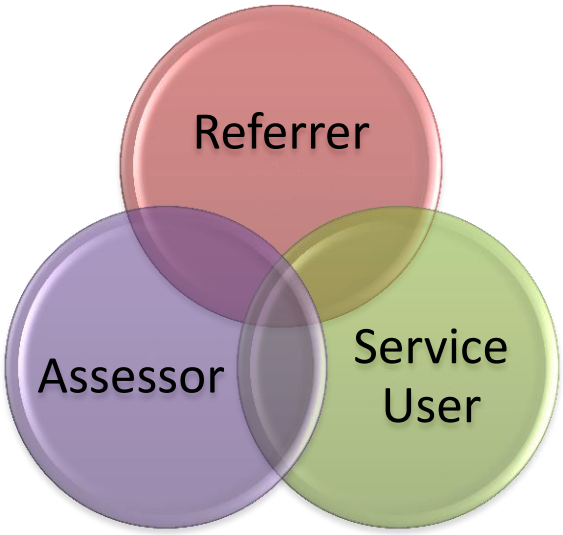

Figure 1: Model of Assessment/ Perspective

Understanding the referrer's perspective and having knowledge of forensic psychiatry allows the assessor to focus on the third circle, the reality that belongs to the service user. This model allows a viewpoint of 'the truth' to be seen from different perspectives by all three involved, where all the circles intersect, and it can also lead to agreements between pairs that may cause difficulties, where only two circles intersect. The strength of the FAF as a boundary object '*lies in its attention to multiple and divergent actors, social worlds, meanings and uses'*, (Fujimura 1992 p175), and this acceptance of differing viewpoints by being, at times, ambiguous and flexible in its application allows the FAF to access different views of the truth as perceived by these divergent actors and social worlds.

The contradictions that can emerge between these different perspectives can be better understood using this model. The questions that need to be considered start to take shape as reflection takes place of the organisation of this process and experiences of it. By asking all those involved in the process what their experiences are, an understanding of that process, allowing consideration of ways to improve it for all those involved, can begin to emerge.

Jane Ussher offers her material-discursive-intrapsychic model, (Ussher 2000a), which came out of her work to understand *madness* as it is experienced by individual women. This was a move away from the positivist/ realist approach to a material-discursive-intrapsychic approach. As Ussher also linked her model to gaining a better understanding of women who suffered domestic abuse, (Ussher 2000b), it was felt that it could equally apply to people who perpetrated violence and/or offending behaviour, and were subject to mental disorder. Ussher's theory was developed into the Forensic Assessment Format, (FAF), (Carey 2008, Bailey 2012 pp161-163) which was used by the Forensic Community Mental Health Team at Ridgeway Forensic Service for the assessment of people referred to the service. It was piloted in 2004, and following feedback from the staff using it, adjusted and implemented as the teams initial assessment format. It acts as an interview schedule as well as a guide for report writing; providing a consistent approach to initial assessment by the Forensic CMHT. The FAF model informed the subsequent assessment method used from 2011 to 2015, the Forensic Collaborative

Assessment Model, (F-CAM) and from 2015, the Combined HCR20^{v3} and SAPROF Structured interview Schedule, (CHASSIS).

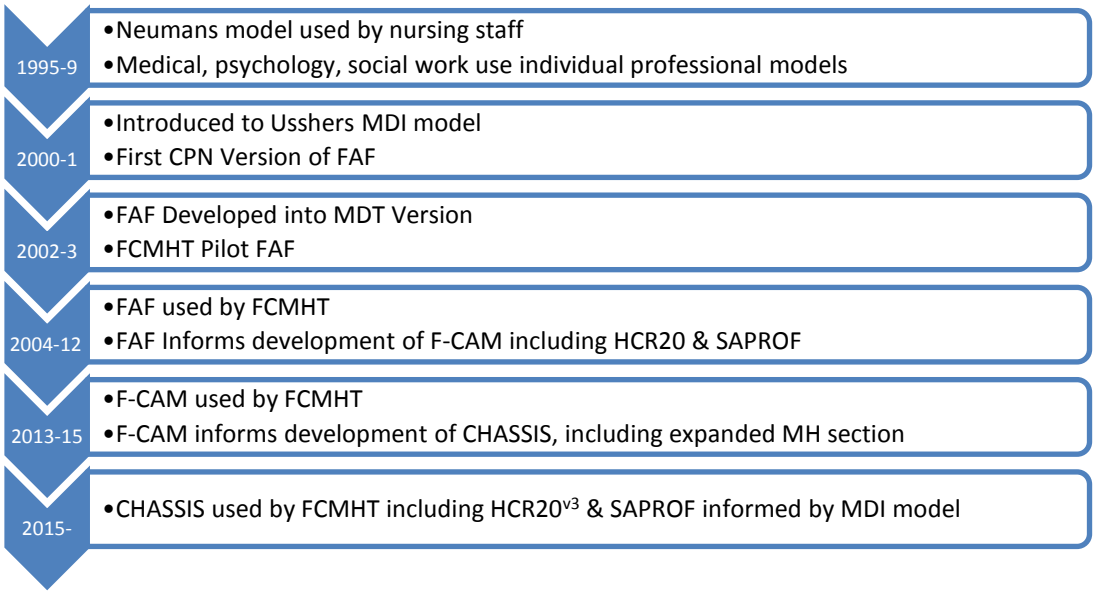

Figure 2: Models of Assessment used by the Forensic CMHT

The models of assessment used by the Forensic Community Mental Health Team, (Forensic CMHT), over the last 20 years that led to the use of the Forensic Assessment Format, (FAF), (Carey 2006) will be discussed in chapter 3.

The final version of the FAF, (appendix 10.1) implements Ussher's material-discursive-intrapsychic model of analysis, with the *Brief Psychiatric Rating Scale*, (BPRS), (Overall and Gorham 1962), and the *Health of the Nation Outcome Scale*, HoNOS, (Wing, Curtis et al. 1996) , to formally assess mental state, needs and risk.

Introducing a new assessment guideline to a group of experienced professionals required a year's planning and consultation. The FAF evolved from a nursing assessment tool into a boundary object that was accessible by the full inter-disciplinary teams involved in forensic psychiatry including professionals, service users, criminal justice agencies, families and community support services who all had some input into its *developing, amending and tailoring*, (Rycroft-Malone, Burton et al. 2015 p83). Each professional group was given the opportunity to feed-back their thoughts and suggestions on the pilot version. This version was then trialled for six months and feedback gained from the staff using it through a feedback audit of this pilot version.

Several months of negotiation on the running order of the tool then followed and adjustments made resulting in the final version being agreed, which is in appendix 10.1, and summarised below in Figure 3.

Section 1	**Demographics:** • Service user detail • Referrer detail • Sources of information	**Consent:** • Assessment • Confidentiality • Research	
Section 2	**Material Aspects:** Social factors • Family • Development • Relationships • Interests • Bereavement • Spirituality • Carer issues • Capacity/ Finance • Child protection • Drug & Alcohol • Presentation Health factors • Medical History • Mental state • Appetite/ sleep Institutional factors • Forensic history • Psychiatric history • Self Harm • Treatments	**Discursive Aspects:** Self-image & Interactions with the world • Role development • communication skills • assertiveness • literacy • stigma • gender issues Expectations Aspirations Miracle question	**Intrapsychic Aspects:** Impact of stress • Physical • Emotional Defence mechanisms • repression • denial • projection • rationalisation • regression • displacement • sublimation • self harm Self esteem/ self worth
Section 3	**Psychometrics:** BPRS HoNOS	**Risk Assessment & Management:** To Self & Others Triggers	
Section 4	**Summary**	**Recommended interventions**	

Figure 3: The Forensic Assessment Format

1.3 Descriptive Data from the Forensic CMHT Database

The Forensic Assessment Format was first used as a multi-disciplinary assessment guideline from the January 2004 launch date of the Forensic CMHT at the Hutton Centre/ Ridgeway until December 2011, when the service developed from it a new assessment process, the Forensic Collaborative Assessment Method, (F-CAM), based on the *Historical, Clinical, Risk 20*, (HCR20) (Douglas and Belfrage 2001) and the *Structured Assessment of Protective Factors* for violence and sexual risk, (SAPROF) (de Vogel, de Ruiter et al. 2009) assessment guidelines. These data cover a period of 5 years, January 2004 to December 2008 and includes 405 service user referral episodes, (Carey 2009). The database has 59 parameters covering demographics, diagnosis, risk profiles, involved professionals and outcomes.

All the data extracted for this part of the research project has been anonymised prior to statistical analysis. A non-electronic key of the anonymising codes was made and printed, and the MS WORD file was then deleted. All identifying characteristics have been anonymised. The volume of these data will further aid the anonymity of the subjects. These data will give a rich source of information on those service users referred to the Forensic CMHT over a period of 5 years between 2003 and 2008. Referral episodes were added to the database when a case was closed and the assessing professionals completed a database form that was then entered onto the database. If a referral was not accepted, the referral details were entered onto a database form, and the referral information recorded. There are limited outcome data on the database; generally it recorded if the team had ongoing involvement in the case, and the nature of that involvement. These quantitative data were not sampled as the entire data for the period were examined from the database which recorded the vast majority of referrals to the Forensic CMHT.

The focus of this data is to describe the cases referred to the Forensic CMHT over a five year period. By recording 59 variables on each referral to the team, a picture of the service users begins to emerge and types can be separated out. Descriptive tables and charts, utilising SPSS, will be presented to give an idea of where the service user groups are located. Blaikie suggested that frequency counts and

distributions can be used to summarize large sets of data and that to establish frequencies of occurrence, these data must be in categories, (Blaikie 2003 p52).

Tables A - V containing all the information from the forensic CMHT database are located in appendix 10.8. They show that 84% were referred once and that 83% were male, 95% white British and 64% were single. They came from all areas covered by the forensic CMHT and the most prevalent diagnosis were psychosis, 29%, and Personality Disorder, 21%. See figure 5 below and Table F for further details.

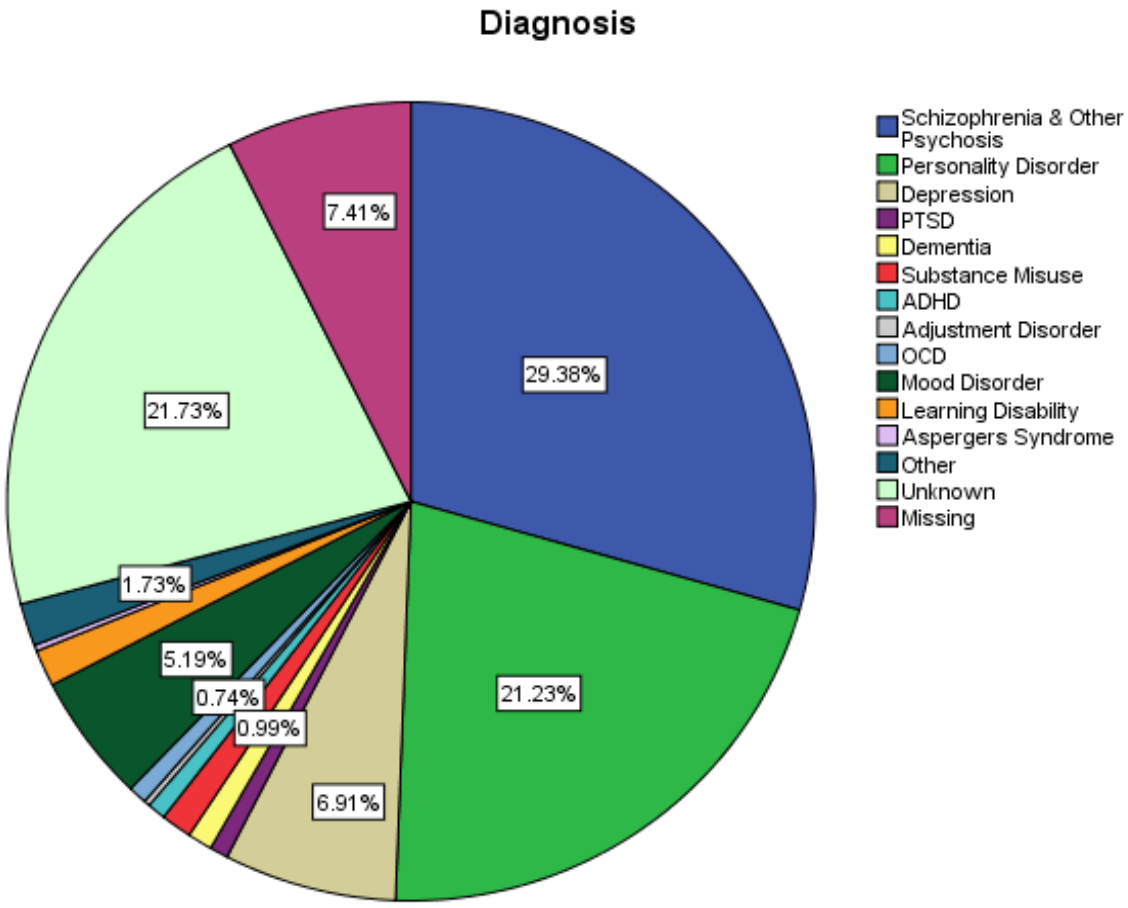

Figure 4: Pre-assessment diagnosis

The age range was 17-89 with a mean of 36 and half of the referrals lived independently with the majority of the remainder in hospital, 32% or prison, 7%. The main risk recorded on the database was of violence to others, with sexual risk, fire setting and stalking also identified, see figure 4 below and Table I.

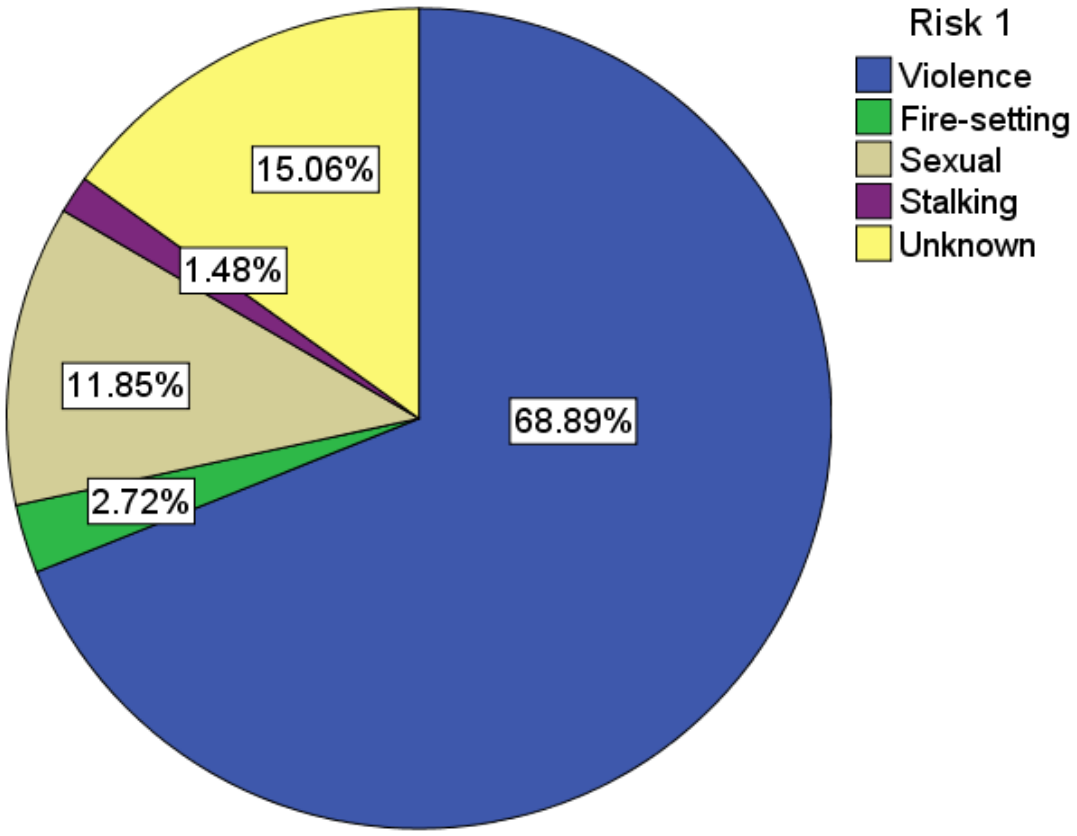

Figure 5: Primary Risk

Of those assessed, just over 195 had a criminal record, with more than half having a recent crime. Over 160 had a history of drug or alcohol abuse. Weapons had been used by 99 with 233 having a history of violence to others. 54 had a history of sexual offences and 30 had a history of firesetting. 166 had a history of deliberate self harm.

Following assessment, advice on risk assessment and management was provided in 276 cases by the assessment report. A minority of cases had ongoing involvement from the Forensic CMHT, of those the main involvement was joint working in 39 cases and relapse prevention in 10 cases.

Of those referred to the Forensic CMHT during the period 2004-2009, the outcomes were as follows in figure 6; see also Table V, appendix 10.8:

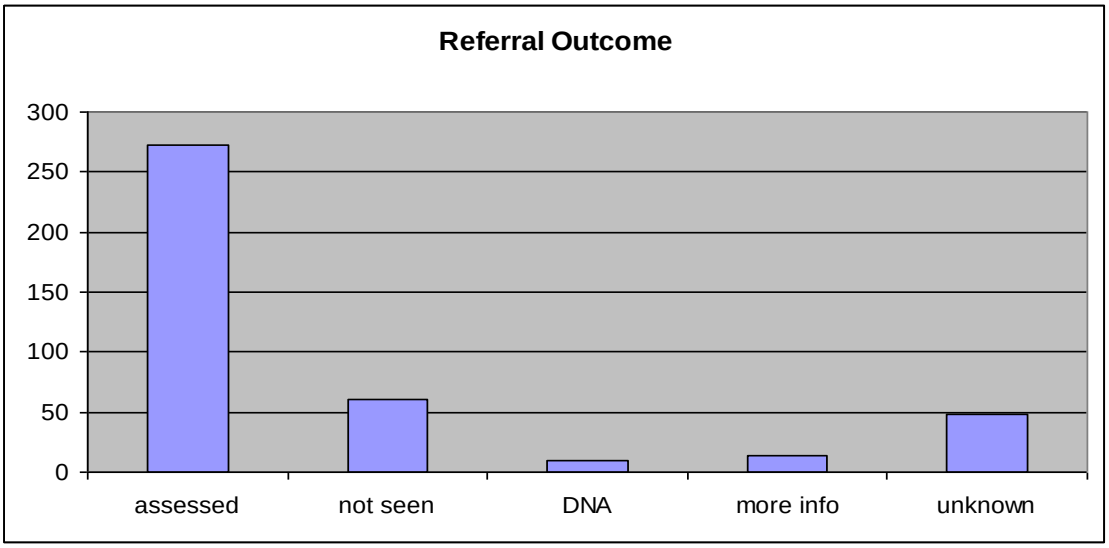

Figure 6: Referral Outcome

A review of the Forensic CMHT database found the following primary risk factors identified, violence, fire-setting, sexual offending and stalking, the prevalence rates are indicated below:

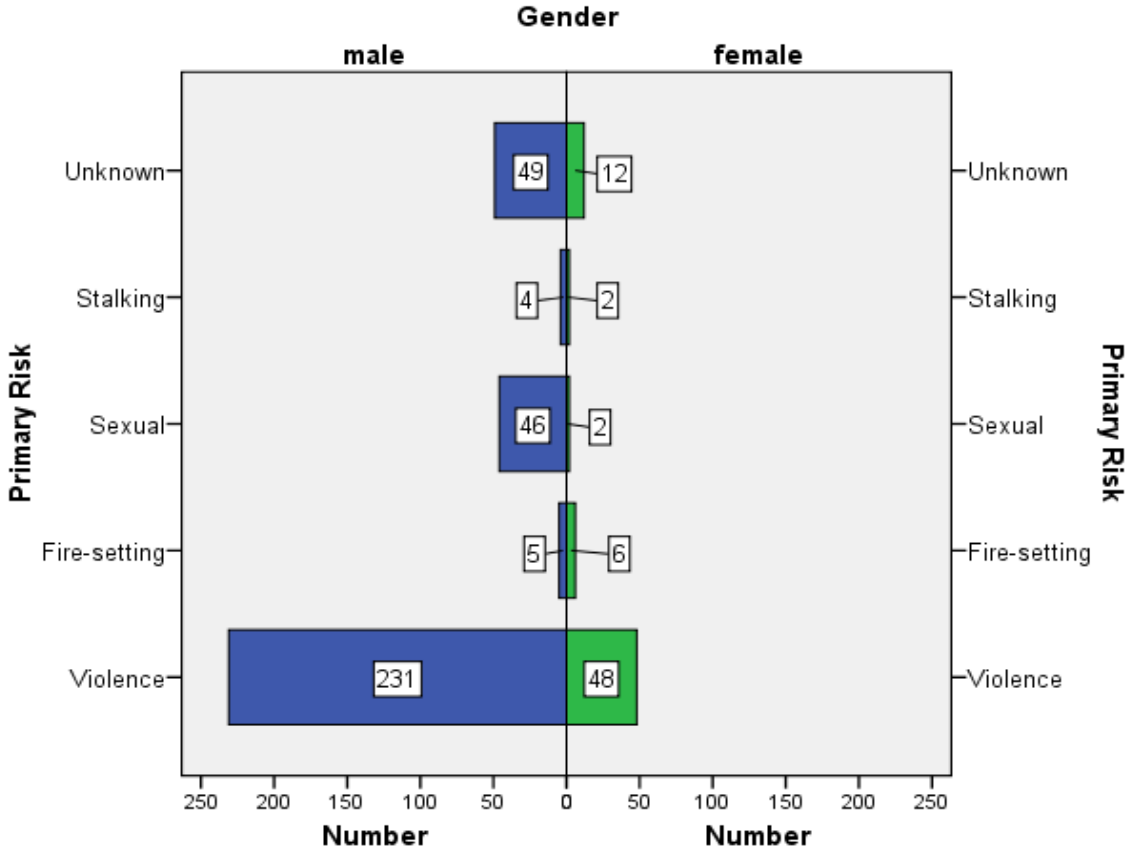

Figure 7: Primary risk by gender, (Carey 2009)

As can be seen, the majority of people referred presented with violence as a major risk factor.

In summary, the average person referred to the Forensic CMHT between 2004 and 2009 was a single white male aged 35 from the Teesside area. He had a psychotic illness with elements of personality disorder and his main risk was violence to others. He had a history of offending and a recent offence. He is likely to have a history of self-harm, with elements of alcohol and drug use possible.

1.4 Summary and Structure of the Thesis

This research project set out to discover how service users, assessing staff and referrers experienced the initial assessment process using the Forensic Assessment Format, (Carey 2006, 2008, Bailey 2012). By taking a multi-perspective approach, as well as using descriptive data from the Forensic CMHT database, (Carey 2009), a wider understanding could be gained.

The experience of the service user, referrer and Forensic CMHT member involved in the assessment process will be analysed from the in-depth semi-structured interviews at the heart of this project of 6 service users, 6 assessors and 6 referrers, including a comparator group who were given the opportunity to share their thoughts on the process of initial assessment in response to questions put to them.

As the project developed, and particularly as these data were analysed, the themes that emerged became more about the experience of the assessment process as seen from the perspectives of the service user, the referrer and the assessor with the FAF acting as a boundary object that also included the wider interdisciplinary team, service users, family members and carers. This may not always achieve consensus, but cooperation remained evident between these social worlds and actors, (Star 2010 p604).

The structure of the thesis started with this section which has set the scene with an introduction to the policy and clinical context in forensic psychiatry as well as briefly

describing the development of the Forensic CMHT and the FAF. Chapter 2 will be a review of the literature looking at government policy, advice and guidance on the development of forensic psychiatry in England and Wales from the 1970's onward along with the advice that was available to inform the assessment of mentally disordered offenders prior to the development of assessment guidelines such as the Forensic Assessment Format. The literature and advice on personality disorder and psychosis will also be explored. Chapter 3 will look at the key theories involved in the development of this project. In Chapter 4, the methodology used for data collection and interpretation including the authors background and motivation that led to the proposal for a research project to look at the FAF and the hypothesis behind it, collaboration; using an holistic approach and improving outcomes and social inclusion for service users. The data gathered will be introduced, examined and interpreted in Chapters 5 to 8 with the findings discussed in various levels of detail and then summarised at the end of each of the findings chapters. The conclusions and implications of the findings will be discussed in Chapter 9. Comprehensive appendixes will be followed by the reference list.

The need for a new approach to assessment in forensic psychiatry is apparent from the literature currently available, and this will be discussed in Chapters 2 and 3. The aim of this study is to show that the Forensic CMHT using the FAF was able to respond to requests from secondary mental health services for the assessment of people with mental health problems who are seen as a high risk to others with a more consistent, holistic and collaborative response.

Footnotes:

1. **Forensic psychiatry** has two priorities, the service user and the general public. The service user could present with a risk of harm to others, resulting in an appearance within the criminal justice system or through an assessed risk of actions occurring that could result in such an appearance without some intervention. The general public benefit from the duty of care that forensic psychiatry offers them. The dichotomy of these two priorities is in the mind of the professional as they make decisions about the needs of the service user. The liberty, freedoms and care of the service user need to be carefully balanced with the duty of care owed to the general public.

2. The **Forensic CMHT** is a collection of professionals who have a role to play in the care of mentally disordered offenders, (MDO), in the community, which includes Prisons, Hostels and Nursing Homes, as well as independent living such as flats and houses. The Forensic CMHT at Ridgeway is made up of more than 20 members of staff and includes nurses, doctors, social workers, psychologists, support workers and clerical staff. They provide a specialist forensic service to the Tees Valley and County Durham area in the North East of England which currently has a population of approximately 1.6 million. The team accepts referrals from adult mental health services in that area, and its referral criteria are that the service users referred must be aged over 18, have a current mental health problem, display a risk to others and be open to secondary mental health services. It also provides a Forensic CMHT service and a social work service to the 150 in-patients in the adult forensic medium and low secure care services at Ridgeway, Roseberry Park in Middlesbrough. The medical and nursing members of the team (up to 2013) provide sessional input to the Durham Cluster of prisons, which includes HMP Durham, HMP Frankland, HMP Holme House, HMP & YOI Deerbolt and HMP & YOI Low Newton. Following a referral being accepted at the weekly multi-disciplinary team meeting, two members of staff are allocated to assess the service user using the Forensic Assessment Format as an interview schedule. A report is then prepared within 4 weeks that summarises the service user's history, presentation, perspectives and risk assessment. The report will give a detailed risk management and intervention strategy. This strategy may involve a period of 'shared care' where members of the Forensic CMHT join the local team to carry out the recommended interventions. Further psychometric tests may be carried out if indicated by the initial assessment interview(s). Service users discharged from Ridgeway may be care co-ordinated by the Forensic CMHT, prior to responsibility being transferred to the local CMHT.

3. The role of a **forensic community psychiatric nurse**, (FCPN), in a forensic community mental health team is to provide a nursing perspective to the assessment, planning, delivery and evaluation of care given to service users. This can involve assessing people referred to the team from adult services; the Durham cluster of prisons and the inpatient low and medium secure adult forensic service at Ridgeway, Roseberry Park in Middlesbrough. It will involve home visits, interventions, rehabilitation, risk assessment and management and the monitoring of medication including the administration of depot injections of long lasting psychotropic medication.

Chapter 2 Review of the Technical Literature

The complexity perspective increases uncertainty. It asks us to embrace it, to face up to it, to find new ways to engage with it.

(Adam 2005b)

2.1 Introduction

To provide context to this research study, this chapter will be presented in two main sections. The first section will provide a brief review of government policy, advice and guidance on the development of forensic psychiatry in England and Wales from the 1970's onward, along with the advice that was available to inform assessment of mentally disordered offenders prior to the development of tools such as the Forensic Assessment Format. The second section will look at two of the major influences on assessment in forensic psychiatry, personality disorder and psychosis. This review will be from the standpoint of current knowledge and best practice including UK government policy, advice and guidance issued over the past few decades and how these policy developments impacted upon assessment in forensic psychiatry.

The assessment of people with mental health problems who come into contact with the criminal justice system and forensic psychiatry has developed rapidly over the past few decades, and this process will continue. By contextualising the influence of the political arena as well as clinical developments, such as those associated with personality disorder and psychosis, the genesis of the Forensic Assessment Format can be better understood.

2.2 Policy Context

2.2.1 Development of Forensic Psychiatry in England and Wales

As this research project is located in the world of Forensic Psychiatry, providing a brief history of its development will help to contextualise the discussions regarding

the assessment process in this arena. Forensic psychiatry developed in the United Kingdom following two government reports in the 1970's, *The Glancy Report* and *The Butler Report*. *The Glancy Report*, (Department of Health and Social Security 1974), recommended that regional health authorities in England and Wales should develop up to 1000 beds nationally to house people with mental health problems who presented as a risk to others, but who did not meet the criteria for high secure care in the special hospitals, Broadmoor, Rampton, Moss Side & Park Lane, the latter two on Merseyside now renamed as Ashworth. It also acknowledged the pressure on beds from those with mental health problems in the prison estate who could not access mental health services. *The Butler Report*, (Home Office and Department of Health 1975), suggested that each regional health authority in England and Wales should set up a forensic psychiatric service with a medium secure unit, MSU, inpatient service as its base that would act as a hub that would link with prisons, probation and the special hospitals. The Butler Report followed the conditional discharge from Broadmoor Hospital of Graham Young who went on to poison two work colleagues resulting in their deaths. The public outcry over this case led the government to act, and they implemented some of Lord Butler's recommendations which resulted in the establishment of forensic psychiatric services in England and Wales.

The first interim medium secure unit in England and Wales was established in Middlesbrough in the late 1970's and early 1980's at St Luke's Hospital and was initially called the Hutton Unit, later the Hutton Centre housing 26 beds. In 2012, this service moved to the 200 bed Ridgeway Forensic Service on the same site, now housing low and medium secure adult, learning disability and autistic spectrum disorder forensic patients, along with a Forensic Outreach Service, the location of this research study, which covers the North Yorkshire, Teesside and County Durham areas.

2.2.2 Assessment in Forensic Psychiatry

Assessment in forensic psychiatry has moved forward from a medical based assessment of symptoms to a more evidence based process that utilises models

such as *Structured Professional Judgement*, (Hart, Sturmey et al. 2011, Logan and Johnstone 2013), which provides guidelines to assist clinicians when conducting an assessment and also includes other stakeholders in the process. Government advice on assessment has highlighted the need to assess mentally disordered offenders, (MDO's), in a comprehensive manner to gain an understanding of their needs, and is a development from the report by John Reed, (Department of Health and The Home Office 1992) which established the need for MDO's to be dealt with by health and social services and not just the criminal justice system. This was further emphasised by the *Health of the Nation Report*, which put Mental Health as one of the five priority areas for improvement by the government, (Department of Health 1992). The introduction of the *Care Programme Approach*, CPA, in mental health services was to ensure that patients in the community received the health and social care that they needed, (Department of Health 1990 para 4) and that they also had their care needs '*systematically assessed',* (Department of Health 1990 para 5.1).

The *National Service Framework* set out 10 guiding values and principles to help shape service delivery that would involve service users and carers in every stage of the service users' journey through mental health services:

- *involve service users and their carers in planning and delivery of care*
- *deliver high quality treatment and care which is known to be effective and acceptable*
- *be well suited to those who use them and non-discriminatory*
- *be accessible so that help can be obtained when and where it is needed*
- *promote their safety and that of their carers', staff and the wider public*
- *offer choices which promote independence*
- *be well co-ordinated between all staff and agencies*
- *deliver continuity of care for as long as this is needed*
- *empower and support their staff*
- *be properly accountable to the public, service users and carers.*

(Department of Health 1999 p4)

As well as setting out these guiding values and principles, the NSF also made suggestions on what assessment of people with *'recurrent or severe and enduring mental illness'* should entail:

> *Assessment should cover psychiatric, psychological and social functioning, risk to the individual and others, including previous violence and criminal record, any needs arising from co-morbidity, and personal circumstances including family or other carers, housing, financial and occupational status*.
>
> (Department of Health 1999 p43)

The advice went on to state that assessment should include physical health and should be multidisciplinary in nature. It advised regular training and the use of a local proforma to ensure consistency. Awareness of service user and carer views, as well as issues around ethnicity, should be prioritised, particularly when agreeing a plan of care following assessment. At the time when the initial version of the FAF was being developed in 2000/1, this advice matched well with the holistic nature of the adapted material-discursive-intrapsychic model.

The development of more traditional perspectives in mental health which have led to the assessment method used by the Forensic Community Mental Health Team, (Forensic CMHT), the Forensic Assessment Format, (FAF), (Carey 2006), will now be considered.

In the second half of the twentieth century, poststructuralism redefined sociological theories by moving away from the objective characteristics of social structures, and looking at the relationship between power and knowledge, (Pilgrim and Rogers 1999 p104-105). DeSwaan makes an important observation that members of the public are encouraged to frame their personal difficulties in professional terms, thereby making them amenable to professional help, (DeSwaan 1990); Coulter sees the public looking for rescue from the discomfort of having to deal with the perceived mentally ill, (Coulter 1973). Such authors provide a modern justification for the professional, and an insight into the development of the forensic assessment format, which is looking at a more inclusive and collaborative model. R D Laing put it in these terms:

> *How can one demonstrate the general human relevance and significance of the patient's condition if the words one has to use are specifically designed to isolate and circumscribe the meaning of the patient's life to a particular clinical entity?*
>
> (Laing 1960 p18)

Laing felt that the language used to describe medical conditions, including mental health conditions were not in the language of the everyday that the patients could understand or access. The argument put forward by Szasz (1984) that psychiatrists are for the modern state what witch-finders were for the church in medieval times, does have some resonance in this context.

Prior to the development of the Forensic Assessment Format, the professionals involved in initial assessment within the Forensic CMHT in this study used different tools. The nursing assessment had used a medical model of history taking and assessing symptoms, prior to incorporating Neuman's model, (Neuman 1996). This model represents the client within the system perspective, holistically and multi-dimensionally. It illustrates the components of five interacting client variables; physiological, psychological, developmental, socio-cultural and spiritual in relation to environmental influences upon the client as a system consisting of basic structure, lines of resistance and lines of defence. The environment broadly defines all internal and external factors or influences surrounding the identified client or client system. Environment consists of three dimensions: internal environment, external environment and created environment. The health of the client is envisioned as being at various levels within a normal range, rising or falling throughout the life span related to adjustment by the client system to environmental stressors. This model, from the United States of America, was envisaged to respond to service user needs in general nursing, and had no formal forensic psychiatry elements.

Medical, social work and psychology assessment were performed using standard assessment techniques from their professions.

The initial reason for developing a new assessment guideline was to improve the quality of initial assessment in forensic psychiatry leading to the access of appropriate and effective interventions for the service user that would improve their quality of life. A secondary objective was to provide a measurable tool to audit those interventions.

Sedgwick, noted two broad responses, (interventions), to emotional problems that can be traced as far back as Ancient Rome; firstly, tampering with the bodies of people with emotional afflictions, today's biological psychiatry, and secondly, offering good counsel, today's psychological therapies, (Sedgwick 1982).

Mann also noted that in ancient Greece, Antiphon offered therapy for grief in the form of catharsis through drama:

> *Antiphon is said to have composed tragedies, both by himself and together with Dionysus the tyrant. While he was still working on poetry, he contrived a techné of alleviating distress, just like therapy that doctors provide the sick. In Corinth he set up a workshop next to the marketplace and put out a sign saying he was able to provide therapy, through words, to those who were distressed. And he comforted the troubled, asking after the causes. But thinking the techné beneath him, he turned to rhetoric.*
>
> *(Mann 2005 pp47)*

The tension between somatic and conversational modes of treatment is still unresolved, and both have iatrogenic effects, (Finn, Bailey et al. (1990)) & (Bergin 1971). This unresolved tension therefore leads me to consider assessment theories from Critical Realism (Ussher 2000a, 2000b), and more formal assessment of physical and psychological symptoms of mental health problems such as the BPRS, (Overall and Gorham 1962).

The variations, over time and cultures, of societies definitions of abnormality, such as who is mad, ill, criminal or perverted, decided who would be locked up, treated or punished. Thus Scull's argument that the mad were locked up in the nineteenth century to segregate them from "normal" society, and to serve an economic and structural need for the growing professions in psychiatry, (Scull 1977) is simply a different truth from the one put forward by Foucault, (1965), i.e. social control of those that are morally inept. Therefore, our definition of who needs "psychiatry" today, in our culture, is an area of developing debate. Whether psychopaths or paedophiles are amenable to "treatment", will depend on the truth of a label of illness or behaviour; mad or bad. Whilst these strong words and the emotions they can bring to the surface can colour our response, the need for a comprehensive formal

tool to assess, without prejudice, becomes more evident. In the end, we can only hope to reflect a wider perspective, without discriminating, in offering our assessment, and strive to avoid reframing the human experience of madness as an object to be managed, manipulated and controlled by psychiatric discourse, (Wirth-Cauchon 2000).

In contrast to Foucault and Scull, who theorised about meaning and truth, R.D.Laing took the discussion out into society, in an attempt to politicise it, with all the subtlety of a 1980's May Day Poll-Tax protest. He wanted discourses between the sane and the insane, which he felt used a human language that had its own rights to its truths. His questioning of societies values, consumerism etc., in the sixties, and how it was marginalizing the insane to the periphery, led him to seek a return to the public space for the insane, from where they had been separated off to asylums in the nineteenth century. His books about schizophrenia, (Laing 1960), and family and interpersonal interactions, (Laing and Esterson 1964) & (Laing 1967), offered a vision of an interpersonal world that valued all experiences. His most notorious book, The Politics of Experience and the Bird of Paradise (Laing 1967), challenged societies understanding of normality and madness, and signalled a break away from mainstream psychiatry. By arguing that the mad can be saner than those described as normal, through a psychotic process akin to the rituals of Amazonian Indians who use substances to gain enlightenment through similar experiences to psychosis, Laing marginalized himself to the status of a maverick guru. However, Kotowicz states that it is time to reintroduce the ideas of Ronald Laing to a new generation, to re-engage the discourse about our understanding of normality and madness, (Kotowicz 1997). Therefore this study will be cognisant of his ideas in formulating its proposals, valuing all experiences equally.

Laing's challenging of the positivists conceptualisation of society, finds a home with the social constructionists challenge of traditional biomedical and psychological models of the human condition. The discourse about the meaning of illness and health, in a cultural and historical perspective, can be constructed from social practices. However, the body cannot be seen as irrelevant in the development of madness or psychological difficulties. Material factors, such as age, social class, ethnicity, relationships and any history of trauma will impact upon the development of

illness. If, however, social constructionists normalize madness, denying its pathology, how can interventions be planned using that model? (Ussher 1991) This disparity between macro-level critique of societies view of mental illness, and the micro-level view of the impact on the needs of the individual, raises the main criticism of this approach to the assessment and treatment of the MDO. Ussher offers some further observations on this point, (Ussher 2000b), if you deconstruct the notion of madness, how can you offer treatment? And how does the notion of focusing on the discursive construction of madness impact upon the individual? To gain a better understanding of peoples mental health, Ussher offers the Material-Discursive-Intrapsychic model of analysis that offers an examination of all aspects of experience, without privileging one above the other, (Ussher 2000a).

However, prior to that consideration, other elements important to assessment of service users in a holistic manner will be taken into account. As has been argued, the truth has a nebulous nature, (Foucault 1967), and the work done by Reed on truth, lying and deception highlights the need for the practitioner to be aware of different perspectives, which can change, dependant on your viewpoint, (Reed 1996). For instance, when performing cross-cultural assessments, it is important not to challenge the value of traditional support systems, imposing western cultural values into the clinician-patient interaction, (Bhugra 1997). In contrast, projecting an understanding of the socio-cultural background of the patient, would aid in distinguishing the culturally bound behaviour from behaviour that reflects actual psychopathology, (Worthington 1992). Therefore, the substantial evidence that black people suffer socio-economic disadvantage in terms of wealth, housing, education and services, (Boast 1995), and Fernando's advice not to invoke stereotypes, (Fernando 1998), but to concentrate on serving patients, points the way towards anti-discriminatory practice. The treatment of service users as individuals, with all their influences and experiences intact and not influenced by the assessor, will lead to a more rounded assessment.

In the world of Forensic Psychiatry, the interests of the service users should be paramount; however, there are other more political considerations. From a political perspective, the aftermath of a serious offence by a forensic service user can influence the future management and care of mentally disordered offenders; e.g. *The*

Clunis Report, (Ritchie, Dick et al. 1994) which highlighted poor information keeping, management and assessment that led to a lack of care planning, relapse prevention and communication between services. By incorporating the concept of the FAF being a boundary object, the sharing of knowledge only within professional networks can be challenged and it can promote cross boundary knowledge sharing, (Kimble, Grenier et al. 2010), particularly during and following the formulation of outcomes between all the social worlds involved.

2.2.2.1 The Forensic Assessment Format

The FAF incorporates sections on demographics, the Material-Discursive-Intrapsychic elements, the *Brief Psychiatric Rating Scale*, (BPRS) (Overall and Gorham 1962) and the *Health of the Nation Outcome Scale*, (HoNOS) (Wing, Curtis et al. 1996) psychometrics, risk assessment, and a summary and recommendations section, (appendix 10.1).

The demographics incorporate the usual details required for a forensic assessment, including forensic status and history as well as details of all the professionals' involved. Referral details and the confidentiality agreement are in this section.

Material aspects have been subdivided into three sections, health, social and institutional factors. Health will ask about medical history; issues around body image, including appetite, weight and eating disorders; sleep pattern; and any use of illicit substances or alcohol. The BPRS score will be incorporated into this section. Social factors will look at issues of gender and relationships, including role and status; economic factors, including issues of dependence; environment, including culture; abuse, as victim and/or perpetrator; bereavement; and employment, including recreation. Institutional factors will assess the impact of prison, psychiatric hospital and care homes/ social services on the service user.

Discursive aspects will assess communication skills; stigma; role conflicts, including expectations and aspirations; developmental problems, taking account of life scripts and the quest for, or lack of, autonomy; as well as gender inequality issues.

Intrapsychic aspects will consider the impact of stressors, such as neglect, guilt and separation, and the defence mechanisms used to cope with them, repression, denial and so on. The internalised expectations of the service user, such as gender role and idealised fantasy, as well as self-esteem/self-worth will be considered in this section.

The summary will be a space that allows the

> '*material, discursive, and intrapsychic aspects of experience...* to be... *examined without privileging one level of analysis above another*, *...that does not make a priori assumptions about causality and objectivity,'*
>
> (Ussher 2000a p219).

This will need the professional completing the assessment to understand the theoretical basis of the model, allowing him/ her to draw out an understanding of the interactions of the three levels of analysis. The recommendations section will suggest an agreement between the Forensic CMHT, the service user and the referrer on interventions that address the interaction of stressors that have arisen from the material-discursive-intrapsychic assessment. The material-discursive-intrapsychic model is discussed in detail in section 3.2.3 in the next chapter.

As models, such as the material-discursive-intrapsychic model, and scales such as BPRS and HoNOS-secure are incorporated into the proposed assessment guideline, the complexity of assessment is highlighted; however, sometimes a multidimensional approach is not possible. An example from clinical practice, to assess an inmate situated in a segregation unit within a high secure prison who refused to leave his cell and talk to the assessor, the assessment was about two minutes at the inmate's cell door with four prison officers. Not enough time to build rapport, but time enough to sense hostility, fear and paranoia. In this situation, an overall measure of the likely severity of an illness is the most that could be given.

2.3 Personality Disorder

Many of the service users referred to a forensic team will present with issues associated with personality disorder, and a large percentage of service users referred to the Forensic CMHT at Ridgeway have some element of personality disorder, (Table F appendix 10.8). This section will offer definitions of personality disorder; it will then look at the prevalence of personality disorder and the provisions available to support people who have this diagnosis. Current best practice for training staff working in this area will be then be discussed. How the criminal justice system fits into the provision of health and social services will be considered along with advice from NICE in respect of people with a diagnosis of antisocial and borderline personality disorder. Finally, collaboration and the provision of services in the community for people with a diagnosis of personality disorder will be discussed.

2.3.1 What is Personality Disorder?

As a major influence on many service users in forensic psychiatry, it is important to define what we mean by personality disorder as it will impact on any assessment undertaken. The two main classification systems used in psychiatry are DSM and ICD. *The Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, (DSM IV), developed in the United States of America, defines personality disorder as:

> '*an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment',*
>
> (American Psychiatric Association 1994).

The 10 Categories defined under DSM IV, are grouped into 3 clusters, although the majority of service users assessed in forensic psychiatry will be in cluster B:

Cluster A *(the 'odd or eccentric' types): paranoid, schizoid and schizotypal personality disorder*

Cluster B *(the 'dramatic, emotional or erratic' types): histrionic, narcissistic, antisocial and borderline personality disorders*

Cluster C *(the 'anxious and fearful' types): obsessive-compulsive, avoidant and dependent*

The International Classification of Mental and Behavioural Disorders (ICD-10), defines a personality disorder as:

> *'…a severe disturbance in the characterological condition and behavioural tendencies of the individual, usually involving several areas of the personality, and nearly always associated with considerable personal and social disruption'*,
>
> (Organisation 1994).

In the UK, the British Psychological Society provides a simpler definition of personality disorder, '*Variations or exaggerations of normal personality',* (Alwin 2006).

The Department of Health report, *Meeting the challenge, making a difference* introduced the three P's, *'For someone's personality difficulties to be considered a 'disorder', those difficulties must be Problematic, Persistent and Pervasive',* (Wood, Bolton et al. 2014). The advice given in that document discourages people from too readily giving someone a diagnosis of personality disorder; consider first they may have complex needs or personality difficulties.

The practical and helpful report, '*Recognising Complexity: Commissioning guidance for personality disorder services'* begins its executive summary by describing the experience of personality disorder:

> '*People with personality disorder (PD) suffer lives of rejection, anguish and alienation. The effects on society are pervasive, chaotic and expensive and cross many organisations, services and systems',*
>
> (Department of Health 2009 p3).

Tyrer and Mulder noted that:

> '*Increasing evidence now suggests that more complex and severe personality disorders have a negative impact on the outcome of most psychiatric disorders. Some indications, however, are there to show that pharmacological treatments may*

not handicap the outcome of pharmacological treatment as much as other types of intervention and may be selectively chosen in this group. Severe personality disorder needs to be identified early in community services as by anticipating and adjusting to its effects it is likely to improve treatment plans and prognosis',

(Tyrer and Mulder 2006).

Peter Tyrer recently updated these thoughts by asserting that *'personality dysfunction constitutes a core feature responsible for many other psychiatric disorders'* (Tyrer 2015 p4). He went on to say that the evidence suggests that if personality dysfunction resolves as a consequence of treatment, other mental illnesses will also resolve and then hypothesised that the presence of personality dysfunction in a child will lead to a greater risk of persisting psychiatric disorders in adult life, and vice versa. More research into this area is suggested.

As can be seen above, there are themes in the various definitions of personality disorder and how it impacts on individuals with the diagnosis. The nature of the disorder is that it can be defined by a lifetime history, usually starting in childhood, of difficulties in interpersonal relationships. These difficulties have usually been informed by trauma which impacts consistently on the individual's ability to follow a life course that meets their needs and desires. Individuals with this diagnosis can be pushed to the boundaries of society and driven to seek rapid strategies for coping with stress such as illicit substances and self harm, but can also include offending behaviours that will eventually lead them to contact with the criminal justice system and forensic psychiatry.

2.3.2 Prevalence of Personality Disorder

The following is edited from a literature review of personality disorder undertaken in 2010, and issued as a report to the Forensic Directorate of the Tees, Esk & Wear Valleys NHS Foundation Trust, *Achieving Potential,* (Carey 2010c).

Personality disorders are complex and common conditions (affecting between 5% and 13% of people living in the community). People with PD may present with a range of physical, mental health and social problems such as substance misuse,

> *depression and suicide risk, housing problems or long-standing interpersonal problems. Some also commit offences and are periodically imprisoned. A small number present a risk to other people and a few, serious danger. The general impact of PD on individuals, families and society is significant.*
>
> Recognising Complexity, (Department of Health 2009 p3)

Coid et al (2006) stated that the weighted prevalence of personality disorder in the general population is 4.4% and that it is common in the community, especially in urban areas. They also noted, when looking at future preventative strategies, that there is

> '…a *high incidence of personality disorder in those who have been in local authority or institutional care… who present to the criminal justice system instead of healthcare',*
>
> (Coid J 2006 p430).

In a small study (n=61) looking at healthy adults, i.e. those without a diagnosable DSM-IV-TR Axis I psychiatric disorder, which can include anxiety, substance abuse and mood disorders, but who have a history of moderate to severe abuse in childhood, when compared to those with no history of abuse,

> '*…the abuse group were more likely to report subclinical symptoms of paranoid, narcissistic, borderline, antisocial, obsessive compulsive, passive aggressive and depressive personality disorders',*
>
> (Grover, Carpenter et al. 2007 p442).

The prevalence of personality disorder has variously been assessed as between 5% and 13% in *Recognising Complexity*. Coid and Grover's reports highlight the incidence of personality disorder in the groups excluded from mainstream society; those coming from the care system, and those who have been abused, these are not necessarily mutually exclusive groups. It seems more likely that these groups may initially present to the criminal justice system, rather than health. The forensic psychiatry services will generally deal with people who have been in contact with the criminal justice system, have a mental disorder – possibly personality disorder(s) – and have issues around substance use and a history of trauma. Identifying these issues at the initial assessment stage can have benefits in planning the provision of

services for the service user. The FAF assesses these areas as part of its comprehensive, holistic approach.

2.3.3 Provision of Services for Personality Disorder

The assessment process in forensic psychiatry is looking to advise which services, if any, are indicated for each service user to meet their needs and reduce any of the assessed risks to themselves or others. The government regularly updates its advice and guidance and the main driver for change in the provision of services for people with a personality disorder was a report from NIMHE, *Personality Disorder: No longer a diagnosis of exclusion,* (National Institute for Mental Health in England 2003a). This report said that the purpose of its guidance was:

- *To assist people with personality disorder who experience significant distress or difficulty to access appropriate clinical care and management from specialist mental health services.*
- *To ensure that offenders with a personality disorder receive appropriate care from forensic services and interventions designed both to provide treatment and to address their offending behaviour*
- *To establish the necessary education and training to equip mental health practitioners to provide effective assessment and management.*

For forensic services, they envisaged that in the future, forensic services would need to consider how to develop expertise in the identification and assessment of offenders thought to have a personality disordered in order to provide effective liaison to *Multi-agency Public Protection Arrangements*, (MAPPA), (National MAPPA Team, National Offender Management Service et al. 2012). It also looked at setting up a number of services nationally to provide a dedicated infrastructure for the assessment, treatment and management of personality disordered offenders. They also considered staff selection, supervision, education and training.

Paragraphs 88-96 give specific advice on the development of forensic service models, (National Institute for Mental Health in England 2003a pp37-38). They envisaged that forensic services should cover treatment and/or management of,

social functioning, mental health issues, offending behaviour and risk and that they should operate in very close partnership with local criminal justice agencies and have good links with the high secure hospitals and prison mental health services. Advice is also given on developing expertise in the identification and assessment of personality disordered offenders and developing close working relationships with specialist PD teams in general mental health. This need to identify and assess supports the aim of this thesis in developing an understanding of the process and suggesting a strategy to achieve a collaborative and holistic assessment of social functioning, mental health issues, offending behaviour and risk.

Breaking the Cycle of Rejection: The Personality Disorder Capabilities Framework, (National Institute for Mental Health in England 2003b) followed on from *Personality Disorder: No longer a diagnosis of exclusion,* (National Institute for Mental Health in England 2003a), in giving advice on education and training development for non-specialist services working with people with a personality disorder. It looks at the majority of people with a personality disorder who do not present a risk to others,

> '*The NIMHE guidance aims to challenge the discriminatory association between personality disorder and dangerousness by putting in place services aimed at reducing vulnerability and promoting more effective coping by individuals',*
>
> (National Institute for Mental Health in England 2003b p10).

They envisage a pathway approach to care and treatment, rather than a revolving door; and they see the development of a skilled workforce as key to achieving these objectives. The pathway should include developing capabilities in:

- Initial access and referral
- Sustained episodes of treatment and care
- Supporting recovery and stepping down from treatment

The Cabinet Office published a report, *Reaching Out: An Action Plan on Social Exclusion,* (The Cabinet Office 2006), which was not aimed specifically at people suffering from a personality disorder, but did state that social exclusion and the subsequent waste of human potential is bad for the whole country, as well as for

those individuals suffering from it. Those excluded, which it notes can include people with a personality disorder, may achieve positive change through early identification, support and preventative action. They identified 5 key principles:

- Better identification and earlier intervention
- Systematically identifying ‘what works’
- Promoting multi-agency working
- Personalisation, rights and responsibilities
- Supporting achievement and managing underperformance

This report also identified that a lifetime approach could pay dividends, and that parental support and skills improvement for parents could help reduce future difficulties. Again, early identification would be supported by a better understanding of the assessment process and a strategy that will provide a collaborative and holistic assessment. This approach is echoed in the Guidance issued on borderline personality disorder and anti-social personality disorder, (National Institute for Health and Clinical Excellence 2009a) and (National Institute for Health and Clinical Excellence 2009b).

The changes to mental health legislation when the *Mental Health Act 1983* was amended by the 2007 Act, (Department of Health 2008), are best summed up by MIND, the UK national mental health charity:

- *there will be a new broad definition of mental disorder and the removal of most exclusions from the coverage of the MHA 1983*
    - *"any disorder or disability of the mind"*
- *the 'treatability test' will be replaced by an 'appropriate treatment test', the new test applying to all the long-term powers of detention*
- *supervised community treatment will be created through the introduction of a new Community Treatment Order, (CTO), for certain service users*
- *new safeguards will be introduced, including a provision for advocacy and amendments to the provisions for displacing and appointing nearest relatives*
- *the roles of approved social worker and responsible medical officer will be replaced by new roles which will be open to a wider range of professionals*
    - *responsible clinician (RC)*
    - *approved mental health professional (AMHP)*

- *provision will be made for powers to reduce the time limits for the automatic referral of some mental health service users to the Mental Health Review Tribunal*

(MIND 2011)

The new broader definition of mental disorder, along with the appropriate treatment test allowed personality disorder to avoid previous excuses for not providing people with a personality disorder assessment, support and treatment, thereby reducing exclusion and stigma.

The reports above, *Personality Disorder: No longer a diagnosis of exclusion, Breaking the Cycle of Rejection: The Personality Disorder Capabilities Framework* and the *Mental Health Act 1983 (as amended 2007)* provided the foundation for *Recognising complexity: Commissioning guidance for personality disorder services, (Department of Health 2009)* which was a pivotal moment in the provision of care for people with a diagnosis of personality disorder. This guidance, chaired by Louis Appleby, introduces its focus by stating that '*People with personality disorder (PD) suffer lives of rejection, anguish and alienation. The effects on society are pervasive, chaotic and expensive and cross many organisations, services and systems',* (p3). It then defines separate tiers of provision:

> *Tiers 1–3 provide services for people with moderate to severe PD. Successful service design elements may include case management and co-ordination, therapeutic community models, a range of psychological therapies, short-term respite or crisis arrangements, service user participation and a focus on recovery.*
>
> *Tier 4 services are for people with severe and complex PD whose needs cannot be met by the community services in Tiers 1–3 and who may require residential treatment.*
>
> *Tier 5 services are for people with severe PD who present significant risk of harm to others. Services are largely commissioned centrally. However, local commissioners need to collaborate with colleagues in Tier 5 services to ensure appropriate step-down arrangements where necessary.*
>
> (Department of Health 2009 p4)

The forensic service should be involved in the identification of people who need tier 4 and 5 services, usually those at risk of moving up to secure inpatient services; offenders moving in the other direction as they need less secure environments; and other groups with complex needs who would meet the criteria for a diagnosis of personality disorder, such as women offenders with complex needs. The profiles of these groups are set out in the guidance, and include those with a chaotic lifestyle, high risk to self or others, women who have completed a sentence or hospital treatment and so on, (p33). It then gives advice on making these services effective by ensuring appropriate assessment, ongoing case management, pathway planning, specialist consultation and liaison and education and training.

Forensic services should also be involved in providing advice and liaison to services operating in other tiers. Again, this government report stresses the importance of assessment, by stating that '*arrangements for specialist assessment for those with very complex presentations and co-morbidities',* should be in place, and that *'Before referral to Tier 4 services, clients should be assessed by a clinician skilled and trained in PD to ensure that the placement is appropriate and that clients are ready'*, (Department of Health 2009 p33). To understand this complex forensic history and presentation, the assessment process needs to explore the individual and their history in a collaborative and holistic manner, such as the methods suggested in this thesis.

2.3.4 Personality Disorder Training for Staff

As noted above, specialist training about personality disorder was a main recommendation from NIMHE report, (National Institute for Mental Health in England 2003a). In December 2007 the Department of Health and Ministry of Justice commissioned the development of a national training framework to support people to work more effectively with personality disorder. This resulted in *The Personality Disorder Knowledge and Understanding Framework,* (Personality Disorder Institute 2011), more usually referred to as KUF. The partnership awarded the contract comprised the Personality Disorder Institute based at Nottingham University; the London based Tavistock and Portman NHS Trust; Borderline UK, (now combined

with Personality Plus and renamed emergence, which was the largest service user and carer support group in the UK focussing on the needs of those living with the experience of personality disorder prior to its liquidation in August 2016); and the Open University, the largest provider of work based education and e-learning materials in the UK. This training framework provides awareness, undergraduate and master's level frameworks facilitated by experts by training and experts by experience.

2.3.5 Criminal Justice System

'The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system', (Bradley 2009) called for a nationwide coverage of specialist teams to divert people with mental health problems to treatment and support at any stage of the criminal justice system. It called for Criminal Justice Mental Health teams to become gateways to mainstream mental health services in the community. And it warns that the new teams could become 'silted up' if mainstream services do not take responsibility for working with offenders. These teams will need assessment processes that can identify people at risk to themselves and others and may have mental health disorders that are in police custody, prisons and health and other community settings.

2.3.6 NICE Guidance for Personality Disorder

NICE, a government body that provides evidence based information for health, public health and social care professionals in the England & Wales, have issued guidance on anti-social personality disorder, (ASPD), and also borderline personality disorder, (BPD). As the Forensic Service will largely be working with ASPD, I have summarised below the main themes from the ASPD guidance, (National Institute for Health and Clinical Excellence 2009a):

- People with antisocial PD should have the opportunity to make informed decisions about their care and treatment, in partnership with healthcare professionals.

- Care of young people in transition between paediatric and adult services should be planned and managed according to the best practice guidance described in *'Transition: getting it right for young people'* (Department of Health 2006)
- Staff working with people with antisocial personality disorder should recognise that a positive and rewarding approach is more likely to be successful than a punitive approach in engaging and retaining people in treatment.
- Healthcare professionals in forensic or specialist personality disorder services should consider, as part of a structured clinical assessment, routinely using: −
    - a standardised measure of the severity of antisocial personality disorder such as *Psychopathy Checklist–Revised* (PCL-R) or *Psychopathy Checklist–Screening Versio*n (PCL-SV) − (Hare 2003)
    - a formal assessment guideline such as *Historical, Clinical, Risk Management-20* (HCR-20), (Douglas and Belfrage 2001), to develop a risk management strategy.
- People with antisocial personality disorder should be offered treatment for any co-morbid disorders in line with recommendations in the relevant NICE clinical guideline.
  Tyrer and Mulder stated that
    - Increasing evidence now suggests that more complex and severe personality disorders have a negative impact on the outcome of most psychiatric disorders. (Tyrer and Mulder 2006 p400)
    - and
    - …that constant attempts may be made to give new treatments for allegedly 'chronic' or 'treatment resistant' disorders that really require some attention to be paid to their personality components. (Tyrer and Mulder 2006 p403)
- For people with antisocial personality disorder with a history of offending behaviour who are in community and institutional care, consider offering group-based cognitive and behavioural interventions (for example, programmes such as 'reasoning and rehabilitation') focused on reducing offending and other antisocial behaviour.
- …services should ensure that there are clear pathways for people with antisocial personality disorder so that the most effective multi-agency care is provided.
- Transition from child and adolescent services to adult services:
  Health and social care services should consider referring vulnerable young people with a history of conduct disorder or contact with youth offending schemes, or those who have been receiving interventions for conduct and related disorders, to appropriate adult services for continuing assessment and/or treatment.

- When assessing a person with possible antisocial personality disorder, healthcare professionals in secondary and forensic mental health services should conduct a full assessment. (guidance is given in detail)
- The evidence base for the treatment of antisocial personality disorder is limited.

The main themes from the *NICE Advice on Borderline PD*, (National Institute for Health and Clinical Excellence 2009b), cover the following areas:

- Access to services, people with borderline personality disorder should not be excluded from any health or social care service because of their diagnosis or because they have self-harmed.
- Autonomy and choice, work in partnership with people with borderline personality disorder to develop their autonomy and promote choice.
- Develop an optimistic and trusting relationship.
- Manage endings and supporting transitions, anticipate the withdrawal and ending of treatments or services, and the transition from one service to another.
- Assessment: community mental health services should be responsible for the routine assessment, treatment and management of people with borderline personality disorder.
- Care planning: teams working with people with borderline personality disorder should develop comprehensive multidisciplinary care plans in collaboration with the service user (and their family or carers, where agreed with the service user).
- When providing psychological treatment for people with borderline personality disorder, especially those with multiple co-morbidities and/or severe impairment, an explicit and integrated theoretical approach should be used by both the treatment team and the therapist, which is shared with the service user, and care should be structured in accordance with this guideline with the provision for therapist supervision in place. Do not use brief psychotherapeutic interventions (of less than 3 months' duration) specifically for borderline personality disorder or for the individual symptoms of the disorder.
- Drug treatment should not be used specifically for borderline personality disorder or for the individual symptoms or behaviour associated with the disorder (for example, repeated self-harm, marked emotional instability, risk-taking behaviour and transient psychotic symptoms).
- Mental health trusts should develop multidisciplinary specialist teams and/or services for people with personality disorders.

These two important documents show the importance of a comprehensive assessment process leading to the development of plans of care for the service user. *The International Personality Disorder Examination* (IPDE), (Loranger 1997), the *Historical, Clinical, Risk 20, version 3* (HCR20v3),(Douglas, Hart et al. 2013) and the *Psychopathy Checklist Revised* (PCL-r), (Hare 2003), are the recommended guidelines that will assess personality and risk. Initial assessment formats, such as the FAF can provide a holistic and collaborative assessment of how the individual fits into the world by utilizing the adapted material-discursive-intrapsychic model.

2.3.7 Collaborative Working and Personality Disorder

Collaboration between agencies can impact on treatment success when working with people who have a diagnosis of personality disorder. The need for an assessment process that is as holistic, comprehensive and collaborative is indicated in this circumstance as different agencies will have differing agendas. Taking a holistic and inclusive approach, such as used by the Coventry Personality Disorder service, can pay dividends; they report that this approach helped this specialist tertiary team integrate into the local mental health community.

> '*We were successful in implementing the innovative community outreach therapy team, and an education and skills facilitation team, and have demonstrated how individual and group therapy can be used in tandem. This means that we are able to help our users systemically in various spheres of their lives, such as with medication, individual therapy, group therapy and with front line staff',*
>
> (Pretorius and Albeniz 2006).

Partnerships between forensic mental health services and the probation service can also have positive outcomes. Blumenthal found that setting up and running a hostel for offenders with a diagnosis of personality disorder returning to the community gained benefits from this partnership arrangement,

> '*The experience of the first two years of the specialist service provision demonstrates that the probation and specialist forensic mental health services can work together to manage violent offenders with high levels of psychological dysfunction as they return to the community',*
>
> (Blumenthal 2009 p52).

The present consensus is that services for personality disorder, particularly in the community, should be partnerships between the NHS, National Offender Management Service, (NOMS), local authority social care and housing services as well as social care services for adolescents and young people.

A partnership between the NHS and NOMS is essential to deliver services for the larger populations of personality-disordered offenders with less serious problems as well as for the smaller numbers who present a high risk of harm to others. The NHS and NOMS share responsibility for those who present a high risk of harm, and the gradual development of closely aligned commissioning for this client group is recommended by the guidelines in the commissioning for personality disorder services, *Recognising Complexity*, (Department of Health 2009). NOMS have produced guidance for staff working with people who have personality disorder issues: *Working with personality disordered offenders. A practitioner's guide*, (Craissati, Minoudis et al. 2011). This was produced for offender managers within NOMS to provide guidance and advice on how to manage people who can be *'extremely challenging'*. It also looked at staff wellbeing in working with this group of people and how they could protect themselves from stress. It gives useful and practical advice on history taking, attachment theory, treatment approaches, boundary setting and supervision.

Increasing the abilities of agencies to work collaboratively with people who have a diagnosis of personality disorder can be achieved through training, joint working and commissioning and integrating services.

2.3.8 Community Services for People with Personality Disorder

As this research project is embedded in a forensic community service, the experience of other community based services was of interest and several were identified as displaying good practice and of achieving good outcomes.

In a 7.5 year retrospective study of service users rehabilitated through forensic services in New Zealand, lower rates of offending were reported, with one service user being rearrested in the forensic group and 9 arrested in the general mental health group. There was a 22% prevalence of PD in the study (n=23 of 105). They suggested that forensic services are more effective because they have more time, increased thoroughness, have a legal mandate and they can use a 'whole of life' approach in their intensive forensic treatment, (Simpson, Jones et al. 2006).

When considering personality disorder in the community it is worth bearing in mind that there are higher prevalence rates of people with both antisocial and borderline personality disorders;

> '*…the minority of community-resident adults with personality disorder who do show this APD/ BPD combination would, compared with others with a PD diagnosis, show high levels of criminality in general, and violent offending in particular',*
>
> (Howard, Huband et al. 2008);

and that:

> '*These individuals' criminal activity is likely to have been driven by emotional disregulation as shown by their high impulsivity, their high anger expression and low control, and their history of aggression',*
>
> (Howard, Huband et al. 2008).

Huband found that the perception among many housing workers that they were left to support clients when mental health services had withdrawn, was significant, and not well understood by mental health professionals. They also identified an unmet training need around personality disorder in services other than mental health, (Huband, McMurran et al. 2007).

The approach in the North West of England was to establish

> '*…three specialist multi-disciplinary Forensic PD Assessment and Liaison Teams. Their task is to assess high-risk offenders with personality disorder and provide a gate keeping and monitoring function to agencies involved in their care and management',*
>
> *(Greenhall 2009).*

One of these teams, the Greater Manchester Personality Disorder Team, which comprised of a psychiatrist, a psychiatric nurse, and two psychologists, assesses men who are serving an Imprisonment for Public Protection (IPP) sentence, (Her Majesty's Inspector of Probation and Her Majesty's Inspector of Prisons 2010), who require transfer from prison or high secure hospital to a medium secure service or are due for MAPPA Level 3 community supervision. Referrals must be over 18, have no mental illness, and exhibit high levels of risk associated with PD. This service uses the *International Personality Disorder Examination*, (IPDE), (Loranger, Sartorius et al. 1994), *PCL-R*, (Hare 2003) and *HCR-20*, (Douglas, Hart et al. 2013) for assessment. In addition, they have developed a structured analysis of an offender's index offence, (West and Greenall 2011). The team has an ethos of integrating assessments with information from collateral resources, such as case files, staff or relatives to increase accuracy. They do not provide clinical interventions, and if admission to medium secure is indicated, they arrange private provision through the North West Specialised Commissioning Team, NWSCT, which funds hospital admissions. This team's practice of gathering collateral information to inform assessments supports that FAF's similar practice of recording where collateral information has been gathered in section 1.

A Cochrane review of CMHT's found that:

> '*Community mental health team management is not inferior to non-team standard care in any important respects and is superior in promoting greater acceptance of treatment. It may also be superior in reducing hospital admission and avoiding death by suicide. The evidence for CMHT based care is insubstantial considering the massive impact the drive toward community care has on patients, carers, clinicians and the community at large',*
>
> (Malone, Marriott et al. 2007).

Mike Crawford indicated that the CMHT model can work with Personality Disorder:

> '*In England, mental health service providers have been asked to ensure that people with personality disorder have access to dedicated community-based*

services. Members of the Delphi panel recommend that such services should provide psychological treatments via out-patient and day-patient units, and should work to reduce stigma associated with personality disorder. They stated that interventions need to be delivered for years rather than months and that service outcomes should be assessed in terms of improved quality of life and social functioning, and reductions in mental distress',

(Crawford 2008).

Tyrer and Mulder found that:

'*Severe personality disorder needs to be identified early in community services as by anticipating and adjusting to its effects it is likely to improve treatment plans and prognosis',*

(Tyrer and Mulder 2006 p400).

Chiesa found that:

'*… this study suggests that medium-term residential psychotherapeutic treatment as part of a long-term step-down program may be an important component for the effective treatment of severe personality disorders, while the role of long-term inpatient stay may need redefining',*

(Chiesa 2004).

The most pressing need identified by *Recognising Complexity*, (Department of Health 2009), in relation to the forensic service, is in establishing a residential or day facility for the assessment, treatment and rehabilitation of people with complex needs associated with personality disorder that have the potential to present a serious risk to others. This will need to be a long term structured hostel/ day service that presents a therapeutic milieu such as a therapeutic community model. It should be jointly commissioned by the NHS and NOMS, preferably with a third sector/ non-profit partner. There could be a pathway to and from the forensic inpatient and prison services, as well as those identified from the community who fit the agreed criteria.

Good community services for people with a diagnosis of personality disorder who present as a risk to others include the ability to spend time with people and work in

partnership with other agencies such as NOMS. These services should also challenge the perceptions of staff from other services and provide comprehensive assessments enhanced by collateral information from other sources, such as police witness statements, to inform the interventions recommended and provided.

2.4 Psychosis

Psychosis and the specific diagnosis of schizophrenia represent a major psychiatric disorder (or cluster of disorders) in which a person's perceptions, thoughts, mood and behaviour are significantly altered. Individuals who develop psychosis or schizophrenia will each have their own unique combination of symptoms and experiences, which will vary depending on their particular circumstances.

(National Institute for Health and Clinical Excellence 2014 p5)

The symptoms of psychosis are usually understood in two elements, positive symptoms such as hallucinations and delusions and negative symptoms such as emotional apathy and social withdrawal. These experiences can be different for each individual and will impact on the person's risk to themselves and others in unique ways; understanding that unique impact is one of the goals of this assessment method, the FAF. Almost 30% of those referrals recorded on the forensic CMHT database had a current diagnosis of psychosis, (Table F appendix 10.8). In this section, psychosis and its impact upon risk will be discussed.

2.4.1 What is Psychosis?

Psychosis...is when you perceive or interpret reality in a very different way from people around you. You might be said to 'lose touch' with reality, (MIND 2016).

Positive symptoms of psychosis can include hallucinations, *perception in the absence of any stimulus*, and delusions*, fixed or falsely held beliefs*. Negative symptoms of psychosis can include *emotional apathy, lack of drive, poverty of*

speech, social withdrawal and self neglect, (National Institute for Health and Clinical Excellence 2014 p5).

2.4.2 The Experience of Psychosis

Sue Estroff offers an ethnography of psychiatric clients in an American community, *Making it Crazy*, (Estroff 1985), in which she offers an insight into the life of people living with psychosis. She offers the perspective that maintaining differentness among clients and with others is amplified and maintained by defining chronic problems in living and being as pathological when it is society that is perpetuating them, (p257). Among issues that she raised was the balance between medicating and supporting people who experience psychosis, she felt that medication was too easy to rely on, (p73, p109). Work experiences were valued by clients, but difficult to attain due to reluctance, fear, anxiety on their behalf. Maintaining work was seen as difficult due to *actual and perceived pressures of a work setting*, (p146). She found that the clients had two categories of people, 'Crazies' and 'Normies' or 'us' and 'them' and that these groups could be further split into insiders and outsiders. By combining these categories into four groups*: Inside Crazies/ Outside Crazies/ Inside Normals/ Outside Normals* she provided an insight into the way their social structures can be inclusive and excluding at the same time, (pp178-9). Sue Estroff offered 12 rules for *Making it Crazy* that provides such an insight that they are reproduced here in full:

1. *Have the ability to become psychotic voluntarily or experience psychosis involuntarily.*
2. *Assume that if you do not take care of yourself someone else will.*
3. *Assume or fear that you will never get better.*
4. *Assume that you are going to fail at almost everything except patienthood.*
5. *Sincerely try new things, like working, every once in a while; but when you get fired, or quit, prove to yourself and others that you really are sick and cannot manage.*
6. *When you get bored or lonely (or genuinely motivated), say you want to go to school or to get a job and get someone to help you try it.*

7. *Assume that medications probably help, but do not trust them or the motives of the people who want you to take them; or assume you have a biochemical imbalance and must take medications for ever, which are supposed to make you well but never quite do.*
8. *Be afraid to get better because:*
    a. *It has been so long that you cannot remember what it is like, and it is therefore unknown and frightening.*
    b. *You might lose the security, safety, predictability, and benefits of your sick role (i.e. lowered expectations of self, and, from others, special attention and income).*
    c. *You might lose your Inside Crazy friends who are like you, and lose your therapist and other Inside Normals; and you have no reason to believe that Outside Normals will like you, and you are not sure that you will like them.*
9. *Do not give up altogether, because then you will have to kill yourself; or perhaps Inside Normals will give up, too, and then you will be rejected. Have just enough hope to keep yourself alive and to keep them involved.*
10. *Do not become too compliant and cooperative with Inside Normals, especially staff, because they will think you are too dependent and will reject you. Or if you really do comply with treatment, then you will either have to get better or get psychotic (just when things are going well so that you can start over).*
11. *Periodically feel guilty, worthless, anxious, miserable, depressed and hostile about all of the above, yourself and others.*
12. *Help everyone else and yourself to make it impossible to be any different.*

(Estroff 1985pp189-190)

Sue Estroff suggests that if *anyone* followed these rules, they would end in the same predicament as the subjects of her book. Conversely, to exit from this predicament, people need to positively change their feelings and behaviour and separate from 'Crazies'; become less reliant on benefits associated with disability; have no contact with psychiatric professionals and decrease or cease medication; and establish other interpersonal and social relationships, (p191). She notes the importance of contextualising *the human, often tragic dimension* of their lifestyle whilst being aware that they are absorbed in the painful but rewarding creation of their day-to-day lives, (p198). The discrepancies between perceived and actual reality and perceived and actual options for the clients is seen as nearly whimsical, often distressing, (p214).

The importance of interpersonal, social and cultural factors is stressed in the context of recognition, treatment and consequences of displaying and experiencing psychiatric problems within a cultural context, (p215), which fits well with the material-discursive-intrapsychic model used with the FAF. The issue of constructing a reality where the burden of proof is on the client that they are not crazy is seen as unfair because we have constructed the social reality of their perpetually negative differentness, (p239).

2.4.3 Psychosis and Violence

Kevin Douglas et al gave us a meta-analysis of psychosis, (N=10,000+), as a risk factor for violence to others which indicated that psychosis was reliably and significantly associated with an approximate 49-68% increase in the odds of violence relative to the odds of violence in the absence of psychosis, (Douglas, Guy et al. 2009 p687). They put this in context by noting that it is smaller than the effects of disorders such as antisocial personality disorder, psychopathy or early onset criminal behaviour, (p693). They advised evaluating psychosis in all violence risk assessments and that this should be done in a way that identifies scenarios that considered which symptoms in what circumstances could precipitate specific risks, (p696). Caveats were offered in this study in that substance-related disorder elevates the risk of violence substantially and that the presence of psychosis should not be seen as necessary nor sufficient for a determination of high risk, (p697).

Jeffery Swanson et al looked at psychotic symptoms and disorders and the risk of violent behaviour in the community and found a fourfold (odds ratio = 3.9) increased risk of violence associated with a particular cluster of psychotic symptoms, (Swanson, Borum et al. 1996). They championed the notion of 'threat/ control-override' (TCO), (Link and Stueve 1994), that sought to interpret the effects of hallucinations or delusions in compromising an individual's ability to control their reaction to harmful and manipulative actions that they *believe* to be directed against them, (Swanson, Borum et al. 1996 p311). The result of their study showed that the presence of hallucinations and delusions increased the odds ratio of violence to 4.1 over the previous year, (p317). Swanson et al stated that the presence of TCO

symptoms, indicating a perception of threat of harm from others included feeling *'that your mind was dominated by forces beyond your control', 'that thoughts were put into your head that were not your own'* and *'that there were people who wished to do you harm'*, would increase the risk of violence by more than double and that people with TCO symptoms had a 56% likelihood of some violence since the age of 18, (p312). They also highlight the relationship between antisocial personality disorder, mental illness, substance use and violence having significant implications for diagnosis and risk assessment, (p323). Their main finding was that when assessing the risk of violence among people with mental illness, measures of current substance abuse and an inquiry into any feelings of being threatened by others and being in control of one's thought processes should be included, (p326). This study was limited by its use of self report measures without any independent corroboration.

These two major studies into any links between psychosis and violence agree that people who are subject to hallucinations and/ or delusions have an increased risk of violence to others. These risks are increased if there are perceived threats from others, co-morbid substance misuse and / or antisocial personality disorder.

2.4.4 NICE Guidance for Psychosis

The NICE guidance, *Psychosis and schizophrenia in adults: prevention and management*, *CG178*, was last updated in March 2014, (National Institute for Health and Clinical Excellence 2014). For this section, the important element was the advice given on assessment and care planning, (pp17-18):

1.3.3.1 Carry out a comprehensive multidisciplinary assessment of people with psychotic symptoms in secondary care. This should include assessment by a psychiatrist, a psychologist or a professional with expertise in the psychological treatment of people with psychosis or schizophrenia. The assessment should address the following domains:

- *Psychiatric (mental health problems, risk of harm to self or others, alcohol consumption and prescribed and non-prescribed drug history)*

- *Medical, including medical history and full physical examination to identify physical illness (including organic brain disorders) and prescribed drug treatments that may result in psychosis*
- *Physical health and wellbeing (including weight, smoking, nutrition, physical activity and sexual health)*
- *Psychological and psychosocial, including social networks, relationships and history of trauma*
- *Developmental (social, cognitive and motor development and skills, including coexisting neurodevelopmental conditions)*
- *Social (accommodation, culture and ethnicity, leisure activities and recreation, and responsibilities for children or as a carer)*
- *Occupational and educational (attendance at college, educational attainment, employment and activities of daily living)*
- *Quality of life*
- *Economic status.*

This prescriptive list includes all the elements present in the *material section* of the FAF and also highlights areas covered in the preceding section on psychosis and violence such as substance misuse and risk to others.

2.4.5 Assessment Guidelines for Psychosis

As the purpose of this research study is to move towards a more inclusive assessment format, that is as practical as it is thorough, complimentary assessments were considered, trying hard to avoid time consuming psychometric tests that require longer to mark than the original assessment. A review of the literature repeatedly offered the same model, the *Brief Psychiatric Rating Scale* (BPRS) (Overall and Gorham 1962), which was developed to provide a rapid assessment of major mental health symptom characteristics. Whilst providing this amount of detail relatively quickly, the authors advised that a more detailed evaluation procedure should generally be used, therefore the use of the BPRS as an extra format in conjunction with the Material-Discursive-Intrapsychic model should provide a comprehensive assessment. The criticism that can be levelled at the BPRS is perhaps more to do with its era of development in the 50's and 60's. The authors advise that it should

take 18 minutes to perform, including 3 min. 'establishing rapport' (Overall and Gorham 1962 p801), and suggests some introductory questions, such as 'How can we be of help to you?' However, the validity of the scale has stood the test of time and development, it is reported to have ' *a good inter-rater reliability*' (Dingemans, Frohn-de Winter et al. 1983), is '*supported as an evaluative tool*', (Inch, Crossley et al. 1997). Morlan & Tan describe it as '*One of the very best rating scales*.' (1998); whilst Ligon & Thyer found it '*useful and efficient in the community setting*', (2000). Within the scale are two groups of ratings, observation and verbal report; the observation of tension, emotional withdrawal, mannerisms and posturing, motor retardation and uncooperativeness; along with the verbal reporting of conceptual disorganisation, unusual thought content, anxiety, guilt feelings, grandiosity, depressive mood, hostility, somatic concern, hallucinatory behaviour, suspiciousness or blunted affect, each of which then gets a rating of 0 - 7 dependent upon the observation or verbal report. It is necessary to confirm the comprehensive nature of the BPRS, and its ability to provide a rapid assessment, and re-assessment.

The *Health of the Nation Outcome Scale*, (HoNOS), was commissioned in 1993 by the Department of Health to measure the health and social functioning of people with severe mental illness. The initial aim was to provide a means of recording progress towards the Health of the Nation target 'to improve significantly the health and social functioning of mentally ill people' (The Royal College of Psychiatrists 2011). They were developed over the next 3 years to measure behaviour, impairment, symptoms and social functioning, and published in 1996, (Wing, Curtis et al. 1996). They are now widely used in the NHS and internationally, including France, Italy, Canada and Australia and New Zealand, (Canuto 2007); (Gigantesco, Picardi et al. 2007); (Burgess 2006).

The *HoNOS secure version 2* was developed by Philip Sugarman and Lorraine Walker at St Andrews Hospital in Northampton, UK, (Dickens, Sugarman et al. 2007) and (The Royal College of Psychiatrists 2011). Interclass correlation coefficients (ICC) were measured as between .39 and .88 for the security scale items in the 2007 study indicating that it is a 'promising outcome measure for users of secure services', (Dickens, Sugarman et al. 2007). However, the ability of the *HoNOS-secure v2* to predict the security level of inpatient status has been questioned in relation to the

risk element, which is a poor predictor. However the needs element is better at predicting inpatient status, (Tiffin, Carey et al. 2011).

Other tools for assessing psychosis were available, such as the *Positive and Negative Symptom Scale*, PANSS, (Kay, Fiszbein et al. 1987), which was a development of the BPRS that included elements to assess negative symptoms of schizophrenia. The *Signs and Symptoms of Psychotic Illness* tool, SSPI, is a 20 point scale that provides a sensitive and reliable measure of the five major clusters of symptoms that occur commonly in psychotic illness, (Liddle, Ngan et al. 2002). Although the PANSS and the SSPI may have been more sensitive to negative symptoms than the BPRS and HoNOS, the Forensic Directorate of the Tees, Esk and Wear Valleys NHS Foundation Trust, required that the *BPRS* and *HoNOS-secure v2* were part of the minimum dataset completed on admission during this study, and reviewed at Care Co-ordination meetings on a 3 or 6 month basis. All the staff received initial training and updates on using the tool. As will be discussed later in the recommendations section, the Maastricht Interview, (Romme and Escher 2000) and the Brown Assessment of Beliefs Scale, BABS, (Eisen, Phillips et al. 1998) are now in use in the latest iteration of the assessment format.

2.4.6 Summary - Psychosis

Understanding the unique impact on service users of their experience of psychosis is vital in formulating risk assessment and management scenarios. The way the FAF proposes to achieve this is by assessing both the positive symptoms using the BPRS and the negative symptoms, mainly in the discursive section, but also in elements of the material and intrapsychic sections.

Understanding the experiences of people living with psychosis provided by Sue Estroff shows the importance of living conditions and work experiences from a sociological perspective. Can the forensic CMHT staff be seen as Inside Normals by the service users they assess? This will depend on the way they are perceived by service users on each occasion. The lessons to be learnt from Estroff's insights include encouraging independence through meeting the service users' needs with

the FAF assessment. This must include understanding their reality and day-to-day lives, encouraging more varied social contacts and appreciating their differentness. Incorporating the Structured Assessment of Protective Factors, (SAPROF), (de Vries Robbé and de Vogel 2014), into the latest assessment format will help in this endeavour as discussed in the recommendations section, 9.7.

Douglas et al show that the risk of violence increases in psychosis, but also advise that substance misuse will exacerbate that risk. The use of risk scenarios, as with the FAF, can identify specific risks and circumstances for individual service users.

Swanson et al show an increased risk ratio of violence in psychosis that is increased in the presence of specific symptoms, defined as TCOs. They also state that antisocial personality disorder/ mental illness/ substance misuse combine to increase the risk of violence to others. These issues are all assessed as part of the FAF.

2.5 Summary

The development of forensic psychiatry in England and Wales following the Butler, (1975), and Glancy, (1974), reports in the 1970's led to a re-examination of the way people in the criminal justice system with mental health problems were assessed and had their needs met. The advice from Reed, (1992), and the prioritisation by the *National Service Framework*, (1999), and the *Health of the Nation*, (1992), reports informed the development of the Forensic Assessment Format, (Carey 2006, 2008, 2010), as a method of assessment that was thorough, collaborative and holistic in identifying the needs of the service users referred to the community service at Ridgeway.

The development of personality disorder services following the two reports from the National Institute for Mental Health in England, NIMHE, *No Longer a Diagnosis of Exclusion, (*2003a*)* and *Breaking the Cycle of Rejection*, (2003b) led to a major change in commissioning advice from the Department of Health with *Recognising Complexity*, (2009). This advice was further developed by the leading researchers in the field, including Peter Tyrer, (Tyrer and Mulder 2006, Tyrer 2009, National Institute for Health and Clinical Excellence 2009b, Tyrer 2015), Connor Duggan,

(Duggan 2009, National Institute for Health and Clinical Excellence 2009a) and Jeremy Coid, (Loranger, Sartorius et al. 1994, Coid J 2006, Moran, Fortune et al. 2008, Coid, Ullrich et al. 2013) in an effort to make personality disorder assessment and treatment a standard part of mental health practice.

Understanding psychosis and its impact on individuals has been enhanced through a review of Sue Estroff's book, *Making it Crazy*, (1985), along with articles by Swanson et al, (1996) and Douglas et al, (2009), concerning psychosis and violence risk and a review of advice offered by NICE, (2014).

A major element of this review of the literature has been looking at current theory and practice in the assessment and treatment of psychosis and personality disorder; any forensic assessment should consider personality and, as Tyrer states *'personality assessment is an essential part of good clinical assessment',* (Tyrer 2015 p5).

The policy, advice and guidance in this chapter from several government departments and the research presented on personality disorder and psychosis supports a thorough, collaborative and holistic approach to assessment in forensic psychiatry.

Chapter 3 Review of the Theoretical Literature

'Critical realism is one example of a material-discursive-intrapsychic approach that can reconcile both the biomedical and psychosocial aspects of experience, as well as incorporate the cultural and historical context in which the meaning about experience is created.'

(Ussher 2000a p221)

3.1 Introduction

This chapter will look at the key theoretical perspectives involved in developing this project, which start with the work of Jane Ussher, (Ussher 1997b, Ussher 2000a, Ussher, Hunter et al. 2002, Ussher 2003). She has offered her material-discursive-intrapsychic model of assessment which was initially written to counter reductionist perspectives of women's' madness and offer more than biological explanations, such as pre-menstrual syndrome, depression or anxiety, and move towards psychological treatments for the *individual* woman to avoid their dependence on men in sometimes abusive relationships, (Ussher 2000a pp207-209). The ideas generated by this line of logic led to a consideration of whether this approach could be mirrored in assessing mentally disordered male perpetrators of violence towards women which, in turn, led to the development of the Forensic Assessment Format, (Carey 2006, 2008, 2010). This challenging of reductionist and positivist perspectives in the social sciences, particularly in forensic psychiatry by using a critical realist approach, incorporating elements of social constructionism and theories put forward by Laing, Logan, Bhaskar, Szasz, Foucault, and others will be explored in this chapter.

This review of the *Theoretical Literature* will link the material-discursive-intrapsychic model from a critical realist perspective towards clinical practice; and will include issues of stigma and power relations which will be contextualised and explored as they pertain to assessment in forensic psychiatry. The concept that the Forensic Assessment Format acts as a *boundary object,* (Star and Griesemer 1989), and promotes cooperation between different social worlds by providing bridges for communication to flow will be considered. A summary linking the literature reviews to the research questions will conclude this chapter.

3.2 Key Theoretical Frameworks

3.2.1 Critical Realism

Critical realism, (Bhaskar 1989), affirms reality as physical and environmental whilst recognising the influences of culture, language, race, gender and social class, (Pilgrim and Rogers 1999). Bhaskar offered insights into the anti-monistic and anti-deductive tendencies in the philosophy of science that necessitated a new ontology, and he offered *'...a reorientation of the place of philosophy towards a non-anthropomorphic conception of humanity in nature'*, (Bhaskar and Lawson 1998 p3). This led to the move away from a positivist conception of science and culminated in a new realist philosophy. He offered several features of this '*transcendental realism',* (Bhaskar and Lawson 1998 p5), starting with the revindication of the theory of being, ontology, as distinct from the theory of knowledge, epistemology. He then offered a critique of the reduction of the real to the actual or empirical without being cognisant of the '*generative mechanisms',* (Bhaskar and Lawson 1998 p6), that may be present and exercised or unexercised, regardless of detection. He then offered the conception that there should be an openness of the stratification and distinction between pure and social sciences and the explanations they offered. As noted above, he also argued for a non-anthropomorphic view of nature but also highlighted that the traditional approaches to the problem of induction fail '*to reveal a crucial ambiguity in the formulation of the problem...',* (Bhaskar and Lawson 1998 p90). Trying to gain an understanding of individual ambiguities is the focus of the approach used by the FAF incorporating the material-discursive-intrapsychic model that emanates from a critical realist approach.

The interaction of biological systems and social stressors, e.g. age and economic factors, can influence the aetiology of mental health problems in a physical or psychological manner that is a result of this '*symbiotic relationship between material, discursive and intrapsychic factors',* (Ussher 2000a p221). The element of critical realism, (Bhaskar 1989) that sees generative mechanisms at work in events and discourses points towards the use of multiple methods in seeking to achieve an outcome, whether it is research methodology, assessment or intervention, particularly in the design of the assessment guideline. Byrne offers a definition of

realism that echoes Bhaskar's discussion above of generative forces that may not be detected, *'In its simplest sense it just means that the world exists separate from our consciousness of it',* (Byrne 2002 p14). This fits well with the complexity perspective offered by Barbara Adam that '*encourages an understanding that appreciates the embodied, embedded, nested and contextual nature of social relations and processes.',* (Adam 2005a). Adam also noted that *'The complexity perspective increases uncertainty. It asks us to embrace it, to face up to it, to find new ways to engage with it*.' (Adam 2005b p2). This will only add uncertainty to the already discussed ambiguity of the process we are trying to understand and leads further support for a holistic and collaborative approach to assessment.

A large amount of time in forensic psychiatry is spent discussing risk assessment and management, which is a fragile art at best; but one that critical realism explicitly rejects as part of '*the "predictive pretensions" of natural science'*, (Ussher 2000a p222). In its search for *generative forces*, critical realism can include other methods, and will allow a more formal risk assessment procedure, such as used in the *Care Programme Approach*, (Department of Health 1990). Another important issue of critical realism is the duality of its acceptance of many possible aetiological routes for the development of mental health problems and the many and differing means of prevention and intervention. This acceptance and scepticism also allows equal legitimacy to be given to lay views, such as anecdotal evidence from practice that service users, relatives and others can have vital information to contribute to the assessment and to the decision making processes about interventions. Indeed, Innes et al stated that:

> *'Through narrative a patient may convey the richness of his/ her story and implore the doctor to consider the dangers inherent in reducing that story to the level of a technical description.'*
>
> (2005 p49).

Critical realism can contribute an ontological perspective that accepts individuals as more than is obvious from a review of symptoms. The perspective offered will look to identify the generative forces at work to contextualize the behaviours that have become apparent as a result of the interaction of biological and social stressors that led to a referral for an opinion from forensic psychiatry.

3.2.2 Anti-psychiatry and Social Constructionism

Madness is a human language...part of the human experience...(Laing) attempted to bring madness back to the public space, where it once was, before it was separated off, incarcerated, confined in lunatic asylums on the outskirts of the great conglomerations where normal citizens conduct their affairs. (Kotowicz 1997 p1). Thus R.D.Laing (1967) offered an alternative explanation of what madness and normality is. In questioning the role of psychiatry, he challenged 'the truth' of madness as a concept, therefore changing the arena of discussion by offering new ways of understanding people's experiences. This challenging of 'the truth' was also being espoused by Foucault (1967) who saw reality as not being self evident, but waiting to be discovered, a product of cognitive activity. This started the move towards Social Constructionism, challenging the positivist assumptions, which included traditional biomedical and psychological research. This was a move away from Social Causationists, (Myers, Lindenthal et al. 1975), (Myers 1974) & (Farris and Dunhelm 1939), who saw reality as factual; and the Social Reactionists (Yarrow, Schwartz et al. 1955) & (Rosenhan 1973), who looked at how others reacted to deviance. Whilst the concepts of truth and madness were being challenged in the 60's, the challengers, Laing and Szasz were becoming popular figures in contemporary culture, therefore increasing the profile of the discussion about the human condition from the backwaters of the 'total institution' (Goffman 1961), to television discussions. Thomas Szasz made a statement that 'mental illness is a myth' in which he explored the lack of biological explanations for many mental health problems, (Szasz 1984). Cresswell noted that

> '*The argument is this. Szasz holds that, "mental illness is not a thing or physical object" (Szasz 1968); it is a theory and, as such, stands in need of empirical support'*, (Cresswell 2008).

Szasz was not saying that mental ill health did not exist, but that its provenance is in the Social Sciences, not the Natural Sciences where the psychiatrists had placed it. In contrast to the arguments Szasz puts forward to place mental illness in the correct category, Foucault looked at truth and knowledge. He stated that knowledge is power, then he proceeded to take this knowledge apart, analyse it, then reinterpret and reassemble it, (Foucault 1967), proving that there is no absolute truth, and thus

raising the question, *"who decides what the truth is?".* As Foucault notes, the classical period saw madness as nothing more than a disease confined in unreason.

> *…what had belonged to disease pertained to the organic, and what had belonged to unreason, to the transcendence of its discourse, was relegated to the psychological. And it is precisely here that psychology was born - not as the truth of madness, but as a sign that madness was now detached from its truth which was unreason and that it was henceforth nothing but a phenomenon adrift, insignificant upon the undefined surface of nature. An enigma without any truth except that which could reduce it,*
>
> (Foucault 1967).

Thus, by dismissing notions of abnormality, which can vary over time and cultures, Foucault offered the interpretation of *abnormal* as relating to those whom society wishes to exclude, returning us to Laing's determination to put 'madness' back into the public domain.

Whilst seeing a greater link between the knowledge of social practices and social actions, to challenge the meaning of health and illness, by taking account of rules, language, relationships and roles, (Burr 2003), a Social Constructionist perspective will not only focus on the individual, who generates an understanding through discourse and internal development of a personal narrative, but also on societies 'accepted' understanding generally. Thus, the central assumption that '*reality is not self evident, stable and waiting to be discovered, but instead it is a product of human activity',* (Pilgrim and Rogers 1999 p18), moves social constructionist thought away from positivist ideals. Whilst the gaze of researchers using Social Constructionist theories, e.g. (McNamee and Gergen 1992) & (Shotter and Gergen 1989) remains on macro social structures, the individual can be relegated to a passive, subsidiary role, thus being conceptualised as a social label or category, making the treatment reliant upon the construction of personal illness. In contrast this dichotomy has been challenged (Greenwood 1994), & (Brechin, Brown et al. 2000) who pointed towards Social Constructionist arguments being theories to explain reality, not a reality constructed through observation of larger social structures. The social constructionist perspective seems fixed upon the bigger picture, trying to explain social structures not individuals.

3.2.3 Ussher's Material-Discursive-Intrapsychic model

The perspective offered by Bhaskar, Critical Realism, recognised that reality, both physical and environmental, exists, but that it is tempered by cultural influences, (Bhaskar 1989). This perspective of Critical Realism has been further developed by Ussher who offers her Material-Discursive-Intrapsychic model of critical realism that will be discussed below; in short, it gives a more rounded, holistic and even framework that is not confined to specific areas, but allows equal credence to be given to all aspects of experience, not just the presenting symptoms, as in the traditional medical model, (Ussher 2000a). As noted above, this fits well with the complexity perspective that

> '*...encourages an understanding that appreciates the embodied, embedded, nested and contextual nature of social relations and processes.'*
>
> (Adam 2005a).

Adam also noted that

> *'The complexity perspective increases uncertainty. It asks us to embrace it, to face up to it, to find new ways to engage with it*.'
>
> (Adam 2005b p2).

The ideas offered by Jane Ussher and Barbara Adam that reality is more complex and will not to be easily understood if you confine your gaze to specific areas while denying others. Reality can be uncertain, vacillating and unresolved and will increase in its complexity when viewed from different perspectives. Achieving a level of understanding of these different perspectives will enhance the assessment process.

In performing an assessment of a '*mentally disordered offender'*, the service users experiences and history; how they feel they fit into the world; and the coping strategies that they use can all feed into a more rounded assessment of needs and risk. Looking just at the current presenting problems will not give the comprehensive assessment needed, as would be achieved using an interview schedule, such as the Forensic Assessment Format. Assessment techniques have developed using different models; medical, psychological and nursing amongst them. The assessment of forensic service users in the first decade of the 21st century continues

to rely on a medical model of history taking and symptom identification with the addition of psychometric tests, such as the *HCR-20*, (Douglas and Belfrage 2001, Douglas, Hart et al. 2013), to tease out risk elements. These techniques rely on a professional assessing a service user to reach an opinion on diagnosis and risk. History taking in isolation cannot provide a full assessment of the service user as an individual, thereby negating the usefulness of any assessment.

Material-discursive approaches have been applied to sexuality, reproduction and health, (Ussher 1997a, Ussher 1997b); & (Yardley 1997), avoiding the purely materialistic or solely discursive standpoints. However, they do not account for the intrapsychic element, which is often left out,

> *'…ostensibly because it is seen as individualistic or reductionist, or not easily accessible to empirical investigation. When intrapsychic factors are considered - for example, in psychoanalytical or cognitive theorizing - they are invariably conceptualised separately from either material or discursive factors'*
>
> (Ussher 2000a p219).

Therefore, by including this unaccounted for intrapsychic element, all three levels are brought together as a model for analysis, the Material-Discursive-Intrapsychic Model. Based in critical realism and feminist standpoint theory, this model provides a basis for assessment that can

> '…*recognize the 'materiality' of mental health problems as they are experienced (by women), intrapsychic pain and defences, and the discursive construction of madness (and femininity) - all without privileging one level of analysis above the others',*
>
> (Ussher 2000a p208).

This helps to avoid the focus on diagnostic categories and notions of madness as discrete and detached from the social and discursive elements that define our existence, (Keller 1985). As Laing put it, when discussing his relationships to patients

> '*…no matter how circumscribed or diffuse the initial complaint may be, one knows that the patient is bringing into the treatment situation, whether intentionally or unintentionally, his existence, his whole being-in-his-world. One knows also that*

> *every aspect of his being is related in some way to every other aspect, although the manner in which these aspects are articulated maybe by no means clear',*
>
> *(Laing 1960 p25).*

Understanding these articulated aspects and the *being-in-his-world* perspective is central to this assessment method, the Material-Discursive-Intrapsychic Model.

What do we mean by material? In the context of this assessment guideline, the level of materiality includes the physical effects of psychological stress; issues around gender, race and cultural inequalities; inequalities in relationships, including economic dependence, usually effecting women in heterosexual relationships; issues of emotional, structural and legal support; employment and educational opportunities, treatment by social services and health workers, along with other institutions; history of abuse or bereavement, as well as family and relationship history. From this list can be seen elements not usually assessed in detail, but that would impact greatly on the level of mental health. For example, previous assessments would ask for a list of relationships and family members, but may not unfurl a history of an oppressive partner who has fostered dependence, denying opportunity and support to the service user. Complexity theory also allows for

> '*Material structure, spatial patterns of networked relations, temporal processes of becoming and the cultural meaning these hold (to be) given equal weight in the analysis',*
>
> *(Adam 2005a).*

What do we mean by discursive? '*To focus on the 'discursive' is to consider social and linguistic domains - talk, visual representation, ideology, culture, and power',* (Ussher 2000a p219). Therefore, the construction of madness, by the professionals, can be seen in the context of the relationship between representations of people and the actual social roles of men and women. Ussher gives the example of 'femininity' being performed or acquired, using the discursive model, as opposed to being pre-given or innate, (Ussher 2000a p220). This following of scripts of femininity is encouraged by family, school and popular culture, such as magazines and television, and leads to a traditional life of subservience to a man, even in the direst of circumstances. In circumstances such as this, women can turn their anger inward,

and resort to self-harming behaviour as a response to the culturally based antagonism between women and their bodies, (Fee 2000b p74). In an assessment using this model, it would therefore be possible to gain an insight into the development of role expectations, and the impact on the service user of conflict between that role and aspirations for a different lifestyle, and the level of psychological impact that this conflict has caused. Ussher offers an insight into why women remain in unhappy, neglectful or violent relationships by using this discursive analysis to suggest that the '*outmoded script of heterosexual femininity'* teaches women to gain happiness through their relationships with men, and be blamed if they fail, (Ussher 2000a p220). This element of the assessment will help to provide an insight into the service users seen who have been in abusive relationships, sometimes for many years, as victim or perpetrator, and even assaulted or killed partners, as an abused wife, or a jealous husband.

What do we mean by Intrapsychic? '*Intrapsychic factors are those that operate at the level of the individual and the psychological',* (Ussher 2000a p220). It is how we cope, or do not cope, with the stressors placed upon us; how we blame ourselves for problems and why. The intrapsychic elements include our psychological defence mechanisms and coping strategies; the way we perceive ourselves, our internalised conception of self. This element of the assessment will help to fill out the picture of the individual, and start to identify possible interventions, such as work on self-awareness and coping strategies.

Feminist Standpoint Theory, which is seen as a sub-type of the critical realist approach by Ussher (2000a), has a specific emphasis on gender at a material and discursive level, giving great weight to the personal accounts of women, (Harding 1991, 1993). Their focus is *for* women, rather than *on* women. In interventions, their approach is, in principle, critically realist, but with a greater focus on gender issues.

Ussher discusses that the epistemological shift from a positivist approach to the material-discursive-intrapsychic approach is a clarification rather than a revolution. She describes this clarification as like the difference between a pinhole camera and capturing images on moving pictures. However, the clarity offered by this method of analysis of the phenomenon of experiences labelled madness is a leap towards her

'*utopian analysis',* and she states that *'If we look outwards from our own ideological and professional boundaries, we may surprise ourselves at what can be achieved', (Ussher 2000a p227)*.

From the perspective of initial assessment in forensic psychiatry, Ussher's Material-Discursive-Intrapsychic Model provides an epistemology that is underpinned by knowledge gained from social and theoretical models as well as empirical knowledge gained from clinical experience.

3.2.4 Boundary Objects

People often cannot see what they take for granted until they encounter someone who does not take it for granted.

(Bowker and Star 1999 p291)

In psychiatry, a breakdown in communication can have catastrophic consequences including events leading to homicide such as with Christopher Clunis, (Ritchie, Dick et al. 1994). One of the main recommendations of inquiry reports following such incidents is to improve communication within health services and with other services involved with mental health service users, (McGrath and Oyebode 2002). Sharing information across different groups, such as health, social services, criminal justice and community services such as housing can be made difficult by issues of confidentiality and the different communication systems these groups use. In providing an assessment format that can inhabit several intersecting social worlds, it is suggested that the information requirements of each can be satisfied, (Star and Griesemer 1989 p393). Leigh Star and James Griesemer offer their method of fostering diversity and cooperation across intersecting social worlds, *boundary objects,* and with Ussher's acceptance of a critical realist approach that incorporates the cultural and historical context of the individuals experiences, (Ussher 2000a p221), this *boundary object* can satisfy the information needs of several elements of the assessment process. The FAF can act as a *boundary object* as it inhabits several intersecting social worlds, Forensic Psychiatry; General Psychiatry; Service Users; Carers/ Relatives; Social Services; Police; Probation; Prisons; Housing;

Benefits Agency; Third Sector/ Voluntary Organisations; Education; Employers and administration staff. Each of these groups can access or contribute information to and from the FAF assessment process. The FAF remains an initial forensic assessment, but can inform decisions on, for example, housing or employment whilst retaining its integrity as a collaborative and holistic assessment guideline, interview schedule and guide to report writing. Boundary objects have *the power to 'speak to' different communities of practice by sharing meaning and learning about each others' perspectives and by acting as (temporary) anchors or bridges*, (Rycroft-Malone, Wilkinson et al. 2011 p2). Whether the FAF can *'speak to'* different communities in this way will be considered in the discussion chapter of this thesis.

Another aspect of boundary objects is their ability to have *'the potential to share meaning and knowledge and to catalyse action among those who coalesced around them'* (Rycroft-Malone, Burton et al. 2015 p81). As noted previously, the purpose of a clinical interview is to '*understand and then do something positive to address the needs identified*.' (Logan and Johnstone 2013 p259). If the FAF can do this by catalysing action and meaningful collaboration among the groups involved with the service user, the potential of the FAF as a boundary object will be released, (Rycroft-Malone, Burton et al. 2015 p85).

Leigh Star and James Griesemer found four types of boundary objects, although stating that this list was not exhaustive:

1. Repositories, these are ordered piles of objects, for example a library
2. Ideal Type, this is an object such as a diagram or atlas which does not accurately describe the details of any one locality or thing, and may be fairly vague, for example a species.
3. Coincident boundaries, common objects which have the same boundaries but different internal contents, for example Tees, Esk & Wear Valleys NHS Foundation Trust.
4. Standardized Forms, devised as methods of common communication across dispersed work groups, for example the Forensic Assessment Format.

(Star and Griesemer 1989 pp410-1)

Examples of boundary objects that are textually based are found in Davies & McKenzie's paper looking at a professional theatre production and a midwifery clinic, (Davies and McKenzie 2004). They find that there is a central boundary object in each area, a script and the body of a pregnant woman and foetus. The task they have is to produce a play in one case, and a mother and infant in the other. For the play, a prompt book is the central document accessed by all those involved, actors, stage managers, directors, lighting technicians and designers. This acts as the boundary object as all these groups make notes and comments in it, which remains a record of the production. In the Ontario midwifery service, the Revised Antenatal Record is the document used by all the professionals involved in the care of the expectant mothers and acts as a *repository* and a *standardised* form of boundary object, (Star and Griesemer 1989 p410). These documents, like the FAF, have a purpose but this purpose is not to simply produce another document. The purpose of the FAF is to encourage and empower the groups involved to cooperate and collaborate to do something positive to address the needs identified by the process of forensic assessment using the FAF.

In developing Care Pathways, Davina Allen saw that these pathways are objects that inhabit *'several social worlds and fulfils a role in structuring relations between them'* (Allen 2009 p355). She goes on to argue that the *'looseness and imprecision makes it highly effective in aligning management, clinical and user interests around healthcare quality...'* (p360). As an example from a healthcare area, this is evidence of the effectiveness of boundary objects in aiding communication between groups. With the FAF, the three main groups are Service Users, Referrers and Assessors all within the health context; sub-groups include the criminal justice system and community based support organisations such as housing, benefits agency and social services. If a boundary object like the FAF can align management, clinical and service user interests it could lead to an improvement in healthcare quality.

The FAF, as a boundary object, needs to be framed in terms of understanding the *'viewpoints of all the actors and worlds involved, and thereby avoid the pre-eminence of any one actor'* (Fujimura 1992 p171); a pre-eminent viewpoint can occur if a model is used that installs a limited definition of the situation which has not been constructed in a collaborative, holistic and inclusive manner. This boundary object

concept links well with the material-discursive-intrapsychic model at the heart of the FAF, which has an approach '*that does not make a priori assumptions about causality and objectivity*', (Ussher 2000a p219). Combining the concept of boundary objects with an assessment process based in critical realism allows information to flow between different social worlds which will promote cooperation.

The FAF became a *Boundary Object* as it was accessed by social worlds including forensic psychiatry, with its different professions; service users, with their different experiences and locations; general psychiatry, with their focus on risk; criminal justice, including prisons, police and probation; support services, including housing and third sector support services; administration staff, including medical and team secretaries. The FAF became *'shared and shareable across different problem solving contexts',* (Carlile 2002 p451), as the information in it was added to and shared with the interdisciplinary agencies noted above who were working with the service user at the time. It had a role in managing the '*tension between divergent viewpoints',* (Bowker and Star 1999 p292), for example, through sharing it at a Multi-agency Public Protection Arrangements (MAPPA) meeting, with the service users consent, risk levels were adjusted and strategies changed as risk was contextualised.

It is useful to remember that in her initial framing of the concept of boundary objects, Leigh Star was *'motivated by a desire to analyze the nature of cooperative work in the absence of consensus'* as *'consensus was rarely reached, and fragile when it was, but cooperation continued,'* (Star 2010 p604). The social worlds inhabited by forensic psychiatry have many access points and agendas that can result in a lack of consensus about the best way forward with a service user, but this does not mean that cooperation ends. Responsibility may be due to statutory regulation, such as court orders or mental health act sections for health and criminal justice members; family ties for relatives; tenancy agreements for housing providers. The FAF can be a boundary object which provides a context to the needs of the service user for the different social worlds involved. An example would be when part of the *Multi-agency Public Protection Arrangements*, (MAPPA) process that acts as an information network when working with high risk offenders. The FAF assessors can access information from the MAPPA members, for example, probation, housing and social

services which could inform elements of the material section. Following formulation, recommendations could then include courses available through probation; accessing particular types of housing seen as beneficial and child contact may or may not be indicated; all of which can be quickly fed back to the appropriate services.

Paul Carlile offered three characteristics of a tool, method or object that made them useful in joint problem solving at a given boundary.

1. A boundary object *establishes a shared syntax or language for individuals to represent their knowledge.*
2. An effective boundary object at a semantic boundary *provides a concrete means for individuals to specify and learn about their differences and dependencies across a given boundary.*
3. At a pragmatic boundary an effective boundary object *facilitates a process where individuals can jointly transform their knowledge.*

(Carlile 2002 pp451-2)

The different groups accessing the FAF, professional, service user and support agencies, can struggle to find a shared language to represent their knowledge. By offering *recommended interventions* rather than primarily risk management as an outcome, the FAF attempts to communicate with and engage all the social groups. The FAF offers a concrete means for individuals to communicate over a given boundary, the initial assessment process that can involve them all. By informing a formulation at the end of the process of initial assessment using the FAF, individuals can jointly transform their knowledge.

The development of the FAF as a standardised form of boundary object discussed here can counter the historical effects of poor communication when working with people who are assessed as having a mental disorder and present as a risk to others noted at the beginning of this section. Bringing some element of cooperation between the agencies, groups and families of service users assessed using this process will impact on the strategies and interventions used to meet their needs and minimise risk to themselves and others.

3.2.5 Case Formulation

This model of assessment aligns well with using forensic case formulation, which has two elements, the *process*, which in this context is the FAF, and the *product,* which is the assessment of needs, which can be obtained through a formulation which is *abstracted, precise and systematic*, (Hart, Sturmey et al. 2011 p119). One of the authors of the article on forensic case formulation above is Caroline Logan, who also offers guidance on '*staying in control of forensic clinical interview and the client*' by engaging certain skills, stating that forensic clinical interviews should consist of five stages:

- Preparation – Anticipate the client, yourself and the strategy for the interview
- Engage and explain – Set the scene
- Account – Baseline/ active/ challenge phases
- Closure - Recap
- Evaluate – Review findings, assess and determine interview outcome

(Logan and Johnstone 2013 p282)

She then goes on to give a comprehensive list of recommendations for risk interviews conducted by forensic clinical practitioners including the following sections:

- Introduction
- Problem clarification
- Baseline evaluation
- History
- Harmful behaviour
- Future risk
- Formulation
- Risk management
- Recall and conclude

(Logan and Johnstone 2013 p288)

These sections fit well with the FAF interview schedule, see figure 3 in chapter 1.2, although they do not seem to build up to the discussion of risk in the same manner. The FAF will look at background and development (History in this method) first rather

than going to Problem Clarification after the basic introduction. Logan agrees that

> *'...a collaborative interview is more likely to ensure that the clients views and aspirations are represented than is one conducted without their fully informed consent and in an atmosphere of suspicion and fear'*
>
> *(Logan and Johnstone 2013 pp289).*

The theories above from critical realism, anti-psychiatry and feminist standpoint along with the thoughts and ideas of Laing, Foucault, Szasz, Burr and Logan offer support for the approach offered in this thesis, the forensic assessment format, a development arising from the material-discursive-intrapsychic model.

3.3 Social Inclusion and service user involvement in research

Social exclusion needs to be addressed, as the service users involved in this research project will be mainly from a '*particular neighbourhood'*, as defined by Madanipour:

> '*Social exclusion is defined as a multi-dimensional process, in which various forms of exclusion are combined: participation in decision making and political process, access to employment and material resources, and integration into common cultural processes. When combined, they create acute forms of exclusion that find a spatial manifestation in particular neighbourhoods',*
>
> (Madanipour, Cars et al. 1998).

This definition of exclusion applies to mentally disordered offenders, particularly those detained in prisons or hospitals, as they have, historically been denied participation in the multi-dimensional process suggested. The prison estate in the UK can be described as a town or a community. In October 2015, it had a population of 85,843, (Ministry of Justice, National Offender Management Service et al. 2015) and the neighbourhood inhabited by the MDO needs to be accurately measured, by social statisticians, so as to inform the political process. Forensic psychiatric beds in western Europe have increased by 110% from 2.5 per 100,000 to 5.3 per 100,000 between 1990 and 2006, (Jansman-Hart, Seto et al. 2011 p332). Byrne makes the

point that political and social scientific discourses cannot be separated if we wish to influence the development of political policy, (Byrne 2005). Bailey notes that:

> *'Service users are now represented on the management committees of mental health Trusts, involved in the training and assessment of mental health professionals, in mental health research and the evaluation of services',*
>
> (Bailey 2012 p88).

With inpatient numbers in forensic psychiatric services in the UK currently standing at approximately 6000, (Health 2013), service users in forensic psychiatry also need to be more involved in the processes that inform change in service delivery. Involving service users from both the prison and hospital services from the start of this research project was a conscious step made towards this inclusion agenda. See 4.3.1.1 below for details of the service user input that helped to set the themes for the questions used in the qualitative elements of this project.

3.4 Stigma and Power Relations

Goffman's analysis of stigma as a social mark of a devalued identity, those deemed as inferior, (Goffman 1963), and the labelling of people as *mentally disordered* or *offenders,* can have a long lasting effect, with people living under the shadow of labels forever, (Saltzman 1999). Goffman described stigma as *'…an attitude that is deeply discrediting within a particular interaction',* (Goffman 1963). In forensic psychiatry, there is an added element of stigma and an imbalance in power relations. Not only are service users subject to the double deviant label of '*mentally ill* and *offender*' (Pilgrim and Rogers 1999 p167), but they are also seen as dangerous, needing to be locked away behind a fence. Being in closed institutions, with little supervision from outside agencies can lead to instabilities within services, and the breakdown of therapeutic alliances, such as found by the Fallon Inquiry into the personality disorder service at Ashworth Hospital, (Fallon, Blugrass et al. 1999). They found that a high secure psychiatric hospital had developed an environment that supported pornography and alcohol on a ward where hospital policies were largely ignored and that paedophile behaviour was allowed to develop. That the

management were unable to control this environment over a period of years, despite it being highlighted by several internal reports remains incomprehensible. A process of outside inspections, such as that by the *Care Quality Commission*, (CQC), (Care Quality Commission 2013) has shown that progress has been made and that current standards of care have been met.

The power relations that develop in institutions can be described within a neo-Weberian framework. The professional has a level of power over the service user that is increased within closed environments, such as forensic psychiatry. The service user has a need to progress which is only possible if the professionals allow it, increasing the service user's dependency. By exercising power over new recruits, professionals can exercise control over juniors, who also remain reliant on superiors for progression. Different professions within the institution will also seek to establish dominance over other occupations working with the service user to maintain their power. Maintaining status and material advantage becomes the primary motivator, rather than the service user progressing through the hospital system, (Pilgrim and Rogers 1999 pp102-3).

Looking at personality disorder and stigma, Newton-Howes noted that

> '*An awareness of a personality disorder diagnosis is associated with a clinician belief that patients will be harder to manage. Objective measures of potential confounders do not explain why this group should be harder to manage. One explanation of this finding is that the label 'personality disorder' is stigmatizing. This may also explain the disparity between clinical and research assessments of personality disorder',*
>
> (Newton-Howes, Weaver et al. 2008).

In looking at CMHT's and personality disorder, Newton-Howes found that

> '*Clinicians believed those with the clinical diagnostic label of personality disorder to be more difficult to manage than personality-disordered patients identified by a research tool who did not carry this label',*
>
> (Newton-Howes, Weaver et al. 2008 p572);

and that

> '*...patients with an overt diagnosis of personality disorder are believed to be harder to manage by clinicians than those with a covert diagnosis of personality disorder', (p574)* and they go on to say that there is '*…the need within a secondary*

care setting, where personality pathology is significantly higher than in the general population, to be aware of not only the possibility of a personality diagnosis but also the need to address a potentially negative professional attitude towards it',

(p576).

Stigma around personality disorder would seem to be a continuing problem when reading this paper by Giles Newton-Howes and others.

Bouman noted in a study of the quality of life of people with a diagnosis of personality disorder or psychosis that

'*Personality and psychotic disorders are both characterized by a chronic course and thus may be expected to have an impact on patients' Quality of Life. Chronic psychotic disorder is often characterized by negative symptoms affecting both personal functioning and social integration. Patients with PD's may also be characterized by failures of social integration as a result of an inability to maintain social relationships. Hence, at first sight, the disabling effect of psychotic and PD's on objective and subjective life circumstances might be similar,*

(Bouman 2008).

Yvonne Bouman makes an important point that people with a personality disorder are also subject to other mental health problems that can further increase the stigma they suffer.

Huband also saw deficits in social function, and noted that '*Social dysfunction is a major problem for people with personality disorder',* (Huband, McMurran et al. 2007).

When Blumenthal looked at the development of a specialist hostels for the community management of personality disordered offenders, he noted that

'*There has also been increased interest in improving public safety through managing the risk of harm to others posed by a small group of serious offenders who suffer from PD. These people tend to have complicated relationships with statutory services: some engage in help-seeking behaviour, albeit in a chaotic fashion, and some avoid it',*

(Blumenthal 2009).

People with a personality disorder can experience a negative response from some professionals who work in psychiatry. It is therefore important that staff should attend training programmes, such as the *Knowledge and Understanding Framework* awareness level training programme, (KUF), (Personality Disorder Institute 2011). A major focus of that training is around demystifying personality disorder and the stigma and attitudes of staff working in the field. By challenging staff attitudes, it is hoped that outcomes will be enhanced.

3.5 Summary

In accepting that madness is part of the human experience, (Kotowicz 1997), Laing challenged our conception of that experience. This challenging of 'the truth', by others, including Foucault (1961, 1965) & (1967), started the move towards social constructionism, and away from positivist assumptions of traditional biomedical and psychological research. The myth of mental illness, (Szasz 1984), critically damaged the medical view of physical causes of mental illness by stating that it would be better served as a social science rather than in with the natural sciences. This move from a positivist to a realist philosophy accepted that generative forces exist separately from our consciousness of them. The reality of social and physical environments, and the impact on individuals of these environments, along with cultural influences, was recognised by Bhaskar, (1989), and led to his perspective, critical realism, being put forward. This is supported by David Pilgrim and Anne Rogers in a chapter entitled Mental Health, Critical Realism and Lay Knowledge,

> '*Our overview of the strengths and weaknesses of differing perspectives within social science towards mental health problems led to us pointing towards critical or sceptical realism as a guiding framework to retain the strengths of both realism and constructivism',*
>
> (Pilgrim and Rogers 1997 pp46).

In applying this theory of critical realism to forensic psychiatry, the need for a model that could provide an assessment of an individual's needs was paramount. One of the problems with social constructionism is that it normalizes madness, denying its pathology, which makes planning interventions difficult, (Ussher 1991). The

introduction of Material-Discursive approaches avoided focusing on one area, allowing a fuller analysis of problems such as sexuality, reproduction and health, (Ussher 1997a, Ussher 1997b); (Yardley 1997). However, this still did not consider intrapsychic elements. With her introduction of the Material-Discursive-Intrapsychic model of analysis, Ussher, (2000a, 2000b), offered a solution to this problem. Thus, the development of a tool for assessment has found a theoretical model that allows the ‘*‘materiality’ of mental health problems…intrapsychic pain and defenses, and the discursive construction of madness’*, (Ussher 2000a p208) to be assessed without giving one element greater privilege over another.

Having Ussher’s model from critical realism to provide a collaborative, holistic and inclusive method of assessment leaves a space for Leigh Star’s *boundary object* principle to provide a method of providing a bridge for communication to flow to inform the assessment and cooperate over the outcomes. This method of satisfying the need for information from the intersecting social worlds inhabited by the FAF assessment can lead to outcomes being more readily formulated and implemented.

Bhaskar (1989), stated that the sceptical element of critical realism allowed the use of multiple methodologies to achieve the outcome, be that research, assessment or planning interventions. With this in mind, and the practical difficulties encountered in the Material section of the assessment guideline, a review of assessment scales provided evidence that the *BPRS*, (Overall and Gorham 1962), would counter the difficulties in assessing symptoms, and also provide a tool for auditing the effectiveness of clinical interventions.

The issues of stigma and power relations discussed above have impacted on the way mental health services are supervised at a statutory level with developments such as the Care Quality Commission and their report into Ashworth Hospital, (Care Quality Commission 2013), giving independent oversight to institutions that provide mental health care.

Logan and Johnston’s helpful advice on clinical interview skills, and formulation (Logan and Johnstone 2013), matches well with the proposed assessment guideline, the FAF.

In considering the impact on my professional practice of this research project, the implementation of this model of assessment has had repercussions in several areas. The training needs of other members of the team had to be considered and the outcomes of the trial period of implementation and the review of the effectiveness of the assessment guideline led to further changes being incorporated. The impact on the philosophy of the Forensic CMHT had to take into account the development of this model of care, the adapted Material-Discursive-Intrapsychic Model, (Ussher 2000a, Ussher 2000b) which led to the final version of the Forensic Assessment Format, (Bailey 2012 pp161-164).

3.6 Research Questions

The two main areas of development that have impacted forensic psychiatry over the past few decades are the changes in Risk Assessment and Management and the rise of Service User Involvement/ Empowerment in mental health services. To improve the assessment and management of risk by involving and empowering service users, it is proposed that the following questions should be asked that look specifically at the areas of using a collaborative and holistic approach and its impact on outcomes and service user involvement in research.

Research Question 1

In deciding how to formulate the questions for this project, a decision was made that the service user should be integral to the process of exploration. The experience of the service user should be given equal weight to the professional(s) assessing them. The first question therefore became a discussion on whether this collaborative approach improved the clinical impression gained.

Is the clinical impression gained from the initial assessment process in forensic psychiatry improved by employing the professional experience of the assessor and the personal experience of the service user collaboratively through the use of a person centred approach?

Research Question 2

The second question then looked at the FAF, and asked if this socially constructed assessment guideline informed the assessment process by making it more holistic; and if so, how?

How does using an assessment guideline, the Forensic Assessment Format, inform the assessment process to make it more holistic?

Research Question 3

The third question envisaged that outcome measures would be available to this project, and that service users would be followed up to assess the outcome of assessment by this process. As part of the database collated in the process of this study, there is information on the direct consequence of assessment, i.e. further psychometrics, joint working, risk assessment or access to a range of clinical interventions. A future piece of work needs to look at the longer term outcomes following assessment by the Forensic CMHT using the FAF. There are some data from the semi-structured interviews giving the views of the involved in the process on what benefit there was on outcomes from this assessment process.

What are the processes influencing outcomes for service users when using the Forensic Assessment Format?

Research Question 4

The final question considers whether the social inclusion agenda is assisted by involving service users in the research process. As will be discussed in detail later, service users helped to set the themes for some of the questions asked in the semi-structured interviews by being part of a focus group and interview discussing initial psychiatric assessment.

Can a collaborative approach to assessment assist the social inclusion agenda and if so how does involving forensic service users in the research process contribute to this?

Chapter 4 Methodology

'An individual's pattern of adjustment and adaptation, and any transformations, could result from all he or she does and all that happens to him or her over time.'

(Griffiths, Borkan et al. 2010 p1631)

4.1 Introduction

To understand the adjustments, adaptations and any transformations that have occurred with the individuals assessed by the Forensic Assessment Format, qualitative methods were applied to collecting and analysing the data. The methodological approach of this research study has been informed by Ussher's work which offers a method of understanding women's madness, the material-discursive-intrapsychic model. Her argument, which emerged from a critical realist and feminist standpoint, led her to highlight the limitations of hypothetico-deductive methodologies that developed from realist/ positivist perspectives, (Ussher 2000a pp209-10). This led to a methodological approach involving a variety of analytical methods being applied. Some of these methods will look to explore the potential of the Forensic Assessment Format as an initial assessment guideline whilst other methods will look to understand the experience of the actors involved in the assessment process, i.e. the service user, the referrer and the assessor.

The empirical viewpoint of the clinician is that the Forensic Assessment Format works, but the academic perspective is more concerned with how it works and what are the processes involved? It is now suggested in this research study that by using a methodology based on analytic auto-ethnography, (Anderson 2006), a discursive scaffold can be constructed to gain an understanding of how well the Forensic Assessment Format approach to assessment achieves its objectives of using a collaborative and holistic approach to improve outcomes and social inclusion for service users. It is further suggested that to gain an understanding of the processes involved, a mixture of thematic, inductive and abductive analysis should be employed.

This chapter will look at three main areas, *Methodological Considerations, Research Design, Data Collection and Data Analysis*. The choice of methodological approaches will be considered in detail in the first part. The design section will look at the qualitative methods used, including a focus group and interviews. This element involved a focus group and nineteen semi-structured interviews. Service users were involved in setting the themes of the interview questions through the use of a focus group and a pre-study interview. A discussion of the research setting will follow to locate the context of the study. The data collection and analysis sections will discuss the methods that were used to collect, examine and interpret these data: Thematic Analysis assisted by NVivo software; and Abductive Analysis, which was used to extract themes from these data. The impact of the methodology from the perspective of ethics and the experience of the informants will also be discussed.

As part of the methods used are directly concerned with the author's access to the team, it is important to understand my background. Since qualifying as a registered mental nurse in 1986, I have spent my career in forensic psychiatry. After qualifying as a Registered Mental Nurse, RMN, I progressed to be an assistant clinical team leader before becoming a team leader within the inpatient forensic service. After more than 10 years with inpatients, I moved into the forensic community service, and have been there for over 20 years. At the beginning of that period, the initial assessment of people referred to the forensic community service was generally completed using a medical model designed to assess for symptoms of mental disorder, not to understand and contextualize the person as an individual.

As a member of the Forensic CMHT throughout this project, I am offering an analytic auto-ethnographic perspective by 'living the data', reflecting on practice and responding to new developments, see Anderson, (2006), in the next section. This approach gives me a unique perspective on the development of the Forensic Assessment Format over more than a decade of development. This approach was first defined by Gold as *Participant-as-observer*, (Gold 1958) where the group is aware of the role of the researcher, but I am more integrated as I am a part of the service being studied.

4.2 Methodological Considerations

This research project took a qualitative approach to gathering data on initial assessment in forensic psychiatry. This was achieved by asking the people involved in the process of initial assessment by the forensic community mental health team, (Forensic CMHT), (Jones 2009), using the Forensic Assessment Format, (Carey 2006, 2008, 2010), to talk about that experience. That involvement falls into three categories:

- Being assessed by the Forensic CMHT
- Referring to the Forensic CMHT
- Assessing someone as a member of the Forensic CMHT.

The database of referrals to the Forensic CMHT was interrogated, '*looking to summarize the characteristics of some phenomenon in terms of distributions of variables'*, i.e. univariate descriptive analysis, (Blaikie 2003 p47); helping to identify and understand the people referred to the team. The database was established in January 2004, and a snapshot was taken at the end of December 2008.

Being aware of Ussher's thoughts that the limitations of hypothetico-deductive methodologies that developed from realist/ positivist perspectives do not sit well with her model of analysis, the material-discursive-intrapsychic model, and an alternative approach had to be considered. An ontological standpoint located in critical realism and complexity theory is not one usually associated with methodologies such as autoethnography and abductive reasoning. In order to bridge the epistemological gap between these approaches the arguments put forward by Anderson, Archer, Byrne, Griffiths, Haig and Timmerman will be discussed. With a critical realist perspective to the model used, and also to some of the methods of analysis, it is worth noting Margaret Archer's comments,

> *'…we have to ask what humankind must be like if 'social science' can possibly serve all of it, that is aspire to universalism. And the answer has to be in terms of a unicity of humanity which sees us as more than similar organic parcels with space-time co-ordinates and proper names.',* (Archer 1998 p193).

The methods proposed in this chapter will seek to be cognisant of the potential to define service users not as similar organic parcels, but as individuals, complicated

unique and insightful. In an effort to understand and gain insight into the mechanisms involved in the assessment process, which are likely to be equally complicated and unique, the methods considered could also be seen as complicated and unique.

Haig suggests that using his abductive theory of scientific method, which he defines as *'...a form of reasoning involved in both the generation and evaluation of explanatory hypothesis and theories'* and that it counters the *'...serious limitation of this common characterisation of scientific inference...* (inductive arguments) which fail... *to acknowledge the importance of explanatory reasoning in science.'* (Haig 2008 p1014) . Stephen Hart and colleagues describe abduction as generating rules from cases and results, where deduction generates results from rules and cases, (Hart, Sturmey et al. 2011 p119). Given *the absence of natural laws (or even strong theories)* required for deductive reasoning to make predictions in mental health, abduction allows rules to be developed from empirical observation.

Abductive arguments generate plausible hypothesis worthy of development to explain surprising empirical facts better than rival explanations. This is not in terms of truth, rather as a preference or *inference to the best explanation,* (Haig 2008 p1015).

In an effort to understand the experiences of the people involved in the assessment process in forensic psychiatry, i.e. those being assessed, those assessing and those referring, using abduction as part of the methodology with an ontological perspective based in critical realism and complexity theory could develop the generation and evaluation of hypothesis to explain the processes that individuals use to create their own version of reality. Hypothesis could also be generated to explain the processes involved in facilitating the generation of life stories that include these experiences and versions of reality.

Timmerman and Tavory note that abductive analysis involves a recursive process of double-fitting data and theories; this should involve sharing research among a *community of enquiry* such as other scholars, presenting at conferences and circulating papers, (Timmermans and Tavory 2012 pp179). This research project has been widely presented at Durham University, through the Institute of Advanced Study, School of Applied Social Science research groups and the Wolfson Research

Institute study days between 2010 and 2014. It has also been presented at conferences as papers and a poster both in the UK and internationally, (Carey 2006, 2008, 2009, 2010, 2010b, 2012, 2013). This process of presenting, defending and discussing the research has allowed encouragement and criticism to enhance the veracity of the analysis. This collaboration between inductive and abductive reasoning has been described as an:

> '*iterative dialogue (both metaphorical and literal) between the data and an amalgam of existing and new conceptualizations*...allows *the methodological precepts of grounded theory (*which*) can stimulate abductive reasoning through a process of revisiting, defamiliarization and alternative casing in the light of theoretical knowledge*',
>
> (Timmermans and Tavory 2012 pp180).

This allows for no specific hypothesis to be used, but an opportunity to examine what emerges from these data.

It is vital to remain aware that an *individual* has experiences that they can recall to the researcher; it is then the researcher's responsibility to present that information in a way that elucidates those experiences and adds it to the knowledge of that particular subject. The individual has been considered as:

> '*...someone constantly in the process of becoming, interacting with his or her context, relating to others and developing over time. The individual emerges through a "dynamic play of relationships that occur over time", including feedback within the body as well as interaction with the physical and social environment',*
>
> *(Griffiths, Borkan et al. 2010 p1631).*

Understanding this emerged individual can be achieved by gaining knowledge of the elements that contributed to their development and the impact on the individual's interactions with the world. As this thesis suggests a novel approach to this endeavour, the material-discursive-intrapsychic model, a novel methodological approach is proposed. Combining critical realism with complexity theory does not usually result in an auto-ethnographical approach being used. However, in this instance, it is suggested that the use of analytic auto-ethnography, (Anderson 2006), abductive reasoning, (Timmermans and Tavory 2012), and thematic analysis, (Glaser and Strauss 1967), will contribute to the generation of theories to explain the

assessment process and the perspective of the three actors involved, the service user, the assessor and the referrer. Having an understanding of the here and now, the present, can only be achieved by understanding the many issues impacting on an individual.

That an individual is living in the present and that 'illness' is only one of many trajectories impacting on that present will be reflected in the assessment we make of the individual as a professional. We also need to be aware that the present is '*something constantly changing, as the present moves to the past and a new present is experienced,'* (Griffiths, Borkan et al. 2010). This concept of the *emergent present* is what emanates from what has gone before, and cannot be fully explained by the processes that have led up to it, as said by George Mead (quoted in Flaherty and Fine 2001). Griffiths et al stated that *'In the emergent present the actions of an individual, and all that influences her or him from across time, find expression', (2010 p1632).* Understanding these expressed actions is more than describing them; it has to involve understanding all those influences. The complex nature of this endeavour leads me to be aware of the meaning of complexity, for example:

> '*...understanding of the character of real complex systems in terms of wholes, parts, interaction of parts with parts, parts with wholes, and of systems with other systems in their environment, within which they are embedded, and which they contain'*,
>
> (Byrne 2002 p163).

This complex interaction of the actors in the systems at the heart of this study, and the interactions of those systems are vital to understanding these data. We need to understand the personal meanings of individuals experiences in the context of their social environments, (Polgar and Thomas 2008 p84).

The use of qualitative methods in social research allows structure to be given to the collection of data in an effort to contextualise the experience of individuals, (Polgar and Thomas 2008 p89). The data collection in this study will include a focus group and semi-structured interviews. Emphasising words is central to qualitative research, (Bryman 2004 p266). To collect these words, I used an auto-ethnographic approach which is described as entailing '...*the extended involvement of the researcher in the social life of those he or she studies', (Bryman 2004 p291).* As a member of the

Forensic CMHT at the heart of this study, I have been involved with those I am studying for more than 20 years. This negates a problem that can arise in ethnographic studies, access. My overt access to a closed setting avoids the negative consequences of a covert approach which, in the forensic psychiatric world, would have been difficult to overcome, such as access to secure facilities including prisons and medium secure hospitals. This '*participant as observer role'* (Gold 1958) allowed me to engage regularly with the people involved in this study. Using this approach I can attempt to convince readers of the '*reality of the events and situations described, and the plausibility of (my) explanation',* (Bryman 2004 p501).

Anderson, (2006 pp375), offers *'analytic autoethnography'* to refer to research *'in which the author is:*

> *(1) A full member of the research group or setting* – (I have been a full member of the community service under study since 1995)
>
> *(2) Visible as such a member in published texts* – (I have presented several papers and reports concerning this research outlining this membership, for example: (Carey 2008, 2010c), (Bailey 2012 pp161-164)
>
> *(3) Committed to developing theoretical understandings of broader social phenomena'*. – (The wider objective of this study is to develop an understanding of the complex nature of the assessment process and contribute to its theoretical understanding.)

As an opportunistic '*Complete Member Researcher'* by occupation, (Anderson 2006 pp379), Anderson feels that this '*confers the most compelling kind of "being there" on the ethnographer'*, (2006 pp379). When considering analysis, Anderson describes first-order constructs or interpretations and the more abstract, transcontextual, second-order constructs of social science analysis, which he sees as an interesting dilemma for autoethnographers, (2006 pp381). The level of reflexivity of this approach involves *'an awareness of reciprocal influence between the ethnographers and their settings and informants'*, Anderson (2006 pp382). This leads to the use of Abductive Analysis, which is '...*a creative inferential process...aided by careful methodological data analysis'*, (Timmermans and Tavory 2012 pp167). Burnier criticised Anderson's article stating that analytical autoethnography attempted to contain the personal element in this research context, (Burnier 2006 p417). Vyran argued against this critique by stating that researcher visibility and reflexivity were

enhanced by using this approach, (Vyran 2006 p405). Indeed, Atkinson insists that '*Anderson is quite right to insist on the analytic aspect of autoethnography',* (Atkinson 2006 p402).

Using an analytic autoethnographic approach and abductive analysis helped to counter the power imbalances inherent in forensic psychiatry by opening the discussion with people outside of this environment. This was achieved by presenting the research project to other professionals and academics both inside and outside of forensic psychiatry. Research forums at Durham University that included academics from other disciplines as well as post-graduate and post-doctoral researchers fed back perspectives from geographers, philosophers and mathematicians among others. Presenting papers at conferences around the UK, Europe and North America provided feedback and constructive criticism and well as feedback from people with a lived experience of mental health problems, (Carey 2006, 2008, 2009, 2010, 2010b, Tiffin, Carey et al. 2011, Carey 2012, Carey and Begum 2012, Carey and Jones 2012, Carey 2013). Revisiting the data following several periods of illness during the course of this research project has allowed a more abductive approach to its interpretation. The approach suggested by Anderson, analytic autoethnography, allows the researcher to *'be there'* and to understand the interplay between the settings and informants, whilst Timmerman and Tavory's abductive analysis is aided by the interplay between the researchers social/ professional position and their intellectual position as influenced by the interplay between ideas and feedback achieved by widely disseminating the ideas generated by this research project.

4.3 Research Design

This section will look at the qualitative methods of this study. The pre-study focus group and interview along with the semi-structured interviews that they informed will be discussed. The usefulness of the forensic CMHT database in describing the people referred to the service at the heart of this study will also be considered.

4.3.1 Qualitative Methods

As noted previously, the qualitative data collection progressed on two fronts, a pre-study focus group and interview and the 18 semi-structured interviews in the main part of the study. The focus group and a pre-study interview will be discussed first and the influence they had on the research interview questions will be considered. A section on the interview methods used will follow.

4.3.1.1 Pre-study Focus Group and interview

> *'...to make sense of our environment, and to make nonsense of it because usually not all is revealed to consciousness and sometimes that is because it is shaped outside our conscious awareness.'*
>
> (Archer 1998 p199)

In an effort to make sense, rather than nonsense, of the data gathered in this project, some of the service users selected were involved in a process of co-production in formulating themes to inform some of the questions for the semi-structured interviews. To uncover factors that '*could influence opinions, behaviour or motivation'* (Krueger and Casey 2009 p19) in initial assessment, the method used was one of individual and focus group based discussions to help set the agenda for that part of the research project in response to service users' perspectives on the assessment process. '*Focus groups are used to gather opinions'*, (Krueger and Casey 2009 p2), and they work when '*participants feel comfortable, respected and free to give their opinion without being judged'*, (Krueger and Casey 2009 p4). They suggested that focus groups

> '*typically have five characteristics or features, (1) people, who (2) possess certain characteristics, (3) provide qualitative data (4) in a focused discussion (5) to help understand the topic of interest',*
>
> (Krueger and Casey 2009 p6).

Focus groups involve a discussion among a small group of people with topics introduced by a facilitator. This can allow matters to come to the surface that may not have been raised in conventional interviews, (Polgar and Thomas 2008 p111). They

work *'when participants feel comfortable, respected and free to give an opinion without being judged.'* (Krueger and Casey 2009 p4). They go on to say that focus groups are seeking to provide understanding and insight, (Krueger and Casey 2009 p199). There are a number of criticisms of focus groups, such as a tendency to intellectualize; not tapping into emotions; participants making up answers; producing trivial results; individuals dominating them and the results being undependable, (Krueger and Casey 2009 pp13-15).

The focus group took place in a high secure dispersal prison in 2008 and was attended by three of the four inmates invited with the size of the group being limited by security issues in the prison Healthcare Centre. All three had previously been assessed using the FAF and had experience of other mental health assessments, both inside and outside the prison system.

The difficulties in organising this group were many; initially, permission was granted by the prison governor to record the discussion using an electronic device, but this was withdrawn on the day of the group due to security issues at the prison, and handwritten notes had to be taken. The demographics of this group aligned well with the parameters of the database sample of service users assessed using the Forensic Assessment Format over the previous few years, (Polgar and Thomas 2008 p33); two were diagnosed with a personality disorder and one with psychosis. Some refreshments were provided for the participants, chocolate biscuits and hot drinks, which were well received and helped to ensure a positive atmosphere to the discussion that followed.

The focus group took place in a room on the Healthcare Centre of a high secure prison. The three participants were all life sentence prisoners well into their sentences. The researcher was allowed to see them on his own as he had been providing sessional input as part of the mental health service into the prison as a Forensic CPN for more than 10 years at that point. The issues arising during the focus group are listed below:

- *When asked about how they feel generally about assessment, a discussion progressed about psychological assessment, later clarified as psychometric testing, where a tool is left with the service user to complete. The group felt that the*

psychologists' assessments left them feeling untrustworthy and paranoid, as the questions were repeated 'to catch them out'. In a more general assessment, such as the FAF, they felt that they could clarify the point and express themselves.

- *They felt that the FAF allows a more comprehensive assessment that does not just focus on the 'event', but allows the development of the circumstances around the 'event' to be more thoroughly assessed.*
- *A majority of the group felt that getting a copy of the assessment is important, but can also feed into paranoia with some people.*
- *Professionals carrying out assessments need to be qualified to carry out those assessments, and there was some discussion about junior staff, particularly trainee prison psychologists, gaining experience before embarking on assessments.*
- *Recommendations can be difficult to implement due to difficulties accessing courses in the prison environment. They felt that follow up to assessments after 6 or 12 months are needed to check if recommendations have been carried out.*
- *A question should be added to every initial assessment: 'what do you feel your needs are?'*

The pre-study Interview took place in a hospital out-patient room, this was intended to be the second focus group but it was attended by only one of the six community-based service users who had been invited, all of whom had previously been assessed using the Forensic Assessment Format. This service user had been initially assessed in prison by members of the Forensic CMHT, transferred to hospital for treatment and then followed up after discharge into the community by the same team. This then became a 1:1 discussion, which was audio recorded and transcribed. When asked about approaches to assessment, the service user replied:

> *"…see, I see support as assessment, but I feel, even now that it definitely is. So if I can get support or assessment from somebody, then it's a welcome thing, it's a thing where they are communicating, where I am communicating how I'm feeling and you help to understand how I'm feeling and that's how..."*

This indicates a process of communication leading to an understanding of how the service user is feeling, a collaborative process. When asked about follow up and reviews, the following statement was made:

"Yea, just to say "when I assessed you 3 or 4 months ago this is how you felt; do you feel any different to that now" Just to take on board what the differences are and move them up."

This indicated that a question could be asked about follow up to the assessment. When we discussed where the assessment should take place, and if a choice should be offered, the service user felt that:

"I think the more important thing is to be relaxed about things and I think you would probably get a truer picture of people when they are more relaxed than having to keep asking people a question about things."

This indicated that a question about where the person to be assessed feels more relaxed for the interview should be included.

When we discussed whether those assessed should get a copy of their report, the service user stated:

"I would think for certain, I thought that was just a normal thing; that it just happened."

Which I felt indicated that this should be included in a question.

We discussed feedback to the referring team, and the service user felt:

"Well what about, you might want to see this individual and you've got nobody there, apart from yourself, but I do ask them if they want a member of staff with them, once you've gone, and they're not coming back until the next week so that there's somebody that can…bear in mind that people are unwell, that there are people out there, sometimes there's so much information, overload sometimes…"

This led to the idea of having a member of referring staff in during the assessment to feed back to the service user details that he may have missed.

The final version of the questions for service users, Forensic CMHT members, referrers and the control group is reproduced in the appendix 10.2; the numbers after the questions indicate whether it was the focus group or interview that influenced those questions.

SECTION	FOCUS GROUP	PRE-STUDY INTERVIEW
1. INTRODUCTION		
2. COLLABORATION		
3. HOLISTIC	**1**	
4.OUTCOMES		
5.GENERAL	**4**	**6**

Table 1 Service User Question Influence

The focus group and pre-study interview have therefore led to a co-production element in the design of this research project. It is interesting to note that the issues raised by the service users covered a lot of general issues about assessment not previously highlighted by the author, for example having a follow up appointment to assess whether recommendations made following the assessment were followed up by the referring team. The number of questions in each section of the semi-structured interview schedule set by themes from the focus group and interview are shown in Table 1.

4.3.1.2 Semi-structured interviews

An interview can be thought of as a dialogue or conversation between interviewers and research participants with the purpose of eliciting information from the participants.

(Polgar and Thomas 2008 p107)

In deciding what type of interview to use, I considered using a structured or standardised interview approach, but felt that this would be too closed and would not allow the interviewee to expand on answers or throw up new areas of discussion.

> '*In qualitative interviewing, the researcher wants rich, detailed answers; in structured interviewing the interview is supposed to generate answers that can be coded and processed quickly*', (Bryman 2004 p320).

A semi-structured interview schedule allows the interviewer to ask more general questions and to have some latitude to ask further questions in response to what are seen as significant replies, (Bryman 2004 p113). '*In qualitative interviewing, interviewers can depart significantly from any schedule or guide that is being used',* (Bryman 2004 p320), allowing new ideas or themes to be followed up. As the research study is looking at individual responses to the forensic assessment process, this freedom from '*the need to standardize the way in which each interviewee is dealt with',* (Bryman 2004 p320) meant a semi-structured approach was indicated.

I decided to carry out the interviews personally, as I have experience of interviewing service users gained in clinical practice in forensic psychiatry since qualifying in 1986. Kvale listed qualifications an interviewer should posses, including being knowledgeable, structuring, clear, gentle, sensitive, open, steering, critical, remembering and interpreting, (Kvale 1996). As a registered mental health nurse, I have experience in utilising those qualifications. The interviews were carried out in locations acceptable to the interviewees; local health centres, prison Healthcare centres and team headquarters. I also decided that the interviews should be audio recorded and I used a digital audio recorder, *Olympus digital voice recorder VN-2000PC*. After some initial tests, I found that the use of a microphone attachment improved the quality of recordings. The advantage of audio recording is that full transcripts of the interviews are possible and these are accessible to independent analysis; the disadvantages are that it can be intrusive, there may be reduced disclosure or refusal to participate and substantial and costly post interview analysis is necessary, (Polgar and Thomas 2008 p111). Recording and transcribing interviews has several advantages, including:

- Correcting memory issues
- Thorough examination of what people say
- Repeated examination
- Public scrutiny

(Bryman 2004 p330)

Transcribing the 19 interviews and the focus group, which totalled over 62,000 words, took an immense effort, helping me to improve my typing skills. This was a very time rich experience, but did allow me to immerse myself in the data. There

were difficulties at times, such as not being allowed to record Focus Group 1 in a prison and interview 1, which had to be recorded on an analogue handheld dictation tape-recorder in the same prison. That analogue recording could not be recorded digitally with the other recordings. There were no refusals to have the interviews recorded, which can be an issue in interviews, (Bryman 2004 p331).

These interviews are seeking to answer the following research questions as outlined in 3.6 above:

- Is the clinical impression gained from the initial assessment process in forensic psychiatry improved by employing the professional experience of the assessor and the personal experience of the service user collaboratively through the use of a person centred approach?
- How does using an assessment guideline that has been socially constructed, the FAF, inform the assessment process to make it more holistic?
- What are the benefits of using such a tool in terms of outcomes for service users?
- Can a collaborative approach to assessment assist the social inclusion agenda and if so how does involving forensic service users in the research process contribute to this?

The questions used were seen as an interview guide with the possibility of follow up questions being asked to clarify points raised by the interviewee; all the questions will be asked and a similar wording used from interviewee to interviewee, (Bryman 2004 p321). In formulating the questions for an interview, Bryman (2004 p326) suggests a series of steps including setting specific research questions, leading to interview topics. These can be revised following review and, in this case, being informed by the focus groups, leading to novel issues being identified, again revising the questions to set the final guide.

The service users interviewed as part of this study included two men and two women detained in the prison system and two men in the community, one who was from the comparator service. Four of the service users had a diagnosis of personality disorder and three had a diagnosis of mental illness, one having both diagnoses. All of them had experience of being assessed by forensic services and, with the exception of the service user from the comparator group, all had been assessed using the FAF by the Forensic CMHT. The demographics of this group again reflected the forensic CMHT

database in that there were four males, two females and that both psychosis and personality disorder were represented. The data collection for the qualitative element of this research project was taken from referrals over a 24-month period between 2009 and 2011. This group included a representative sample of those assessed by the team in all three areas, community, prison and the comparator group.

The referrers to the team were chosen from the sample that had referred most cases to the team, and covered both prisons and a representative sample of areas within the large geographical range of the teams NHS Trust. Two of the referrers interviewed were Mental Health In-reach Service Managers from the prison service, one from a local female prison the other from a high secure male dispersal prison. The other four referrers were from different community services within the NHS Trust where the study took place. Four of the referring group were nurses, three of whom were team managers; one was a social worker and another was a consultant psychiatrist, all of them had referred several times to the Forensic CMHT.

The assessors were all members of the Forensic CMHT with at least five years experience of forensic assessment. A consultant forensic psychiatrist, a forensic psychologist, a forensic CPN and a forensic social worker were chosen from the team on the basis of those most experienced in using the Forensic Assessment Format. They had all worked in the team during the collection of data for the database and had experience of using the FAF.

The number of interviews was reduced from 24 in total to 18 as it became increasingly difficult to recruit service users into the study. '*Knowing when to stop is not an easy or straightforward matter in ethnography', (Bryman 2004 p309)* and as six of each group had been interviewed, I drew a line.

The comparator group is a forensic community service from a neighbouring NHS Trust that does not use the Forensic Assessment Format. Their service is divided into a specialist personality disorder team, and a generic Forensic CMHT. The sample from that team was chosen randomly by a member of Personality Disorder Team, including one member of staff from each part of the service. It was not possible to recruit a service user who had a mental illness from the Forensic CMHT,

but a service user with a personality disorder was interviewed. The use of a comparator group gave some indication of opinion from people using an assessment approach that is different to the Forensic Assessment Format.

The 22 participants involved in this study are listed in table 2 below:

	Number	Group	Participants	Sub-Groups
Research Group	5	Service Users	3	Male
			2	Female
	6	Referrers	2	Prison Based
			4	Community Based
	4	Assessors	1	Psychologist
			1	Social Worker
			1	Psychiatrist
			1	Nurse
Comparator Group	1	Service User	1	Male
	2	Assessors	1	Occupational Therapist
			1	Nurse
Focus Group	3	Service users	3	Male prison based
Pre-study Interview	1	Service user	1	Male community based

Table 2: Participant groups and sub-groups

Appendix 10.2 contains the three sets of question used in this research project, one each for Service Users/ Referrers/ Assessing Staff and indicates the questions that were informed by themes from the focus group and pre-study interview. The questions for each group were largely similar with adjustments made to take into account the background of each respondent group.

4.3.2 Forensic CMHT database

Why, then, 'tis none to you; for there is nothing either good or bad, but thinking makes it so: to me it is a prison.

(Shakespeare 1975 p1084)

Whilst Hamlets wish for ignorance on the state of his prison, (Denmark), may seem somewhat removed from this methods chapter, it has been difficult to avoid the truth of the situation and to accept that a mixed methodological approach to this research study has not been possible and that the result is a purely qualitative approach with the added benefit of descriptive data. The Forensic CMHT database, which had 405 referral episodes recorded, was used to describe the service users referred to the team between 2004 and 2009. As there are no formal outcome measures recorded in the database, such as readmission or reoffending rates, these descriptive data could not be analysed for outcomes, however, they were examined, interpreted and presented to provide a picture of the service users referred to the service under study over a five year period, see appendix 10.8.

The information for the database was collected when staff in the team completed a datasheet following a service user being discharged from the Forensic CMHT. This information was then entered into the MS EXCEL spreadsheet that was the Forensic CMHT database. It was evident that not all the discharged service user information was entered onto the database as staff did not always complete the datasheet. From analysis of the records, between 80-90% of service user referral episodes in that period were entered into the database, and this is equates to a large sample of the cases assessed in the period of time studied, i.e. January 2004 to January 2009.

The focus of the Forensic CMHT database in this project is to describe the cases referred to the Forensic CMHT over a five year period. By recording 59 variables on each referral to the team, a picture of the service users begins to emerge and types can be separated out. Descriptive tables and charts, utilising SPSS, will be presented to give an idea of where the service user groups are located.

These data consisted of demographic information about the service users referred, information about the referrer, diagnostic data and data on risk profiles as well as information on what the outcome of the referral. This was by no means a comprehensive list of all the service users referred to the service. Electronic registration of referrals did not occur until 2009 and the introduction of the PARIS system of electronic health records. It does, however represent a large majority sample of those referred to the Forensic CMHT over the period.

As the project developed, it became apparent that these data from the Forensic CMHT database were descriptive and would not lend themselves to outcome analysis as there were no concrete outcomes to measure. The decision was taken to use these data to provide a description of those service users referred to the Forensic CMHT and this information is in Chapter one, section 1.3.

4.4 Research Setting

This research project has been set within the forensic psychiatric service of the Tees, Esk & Wear Valleys NHS Foundation Trust and included the Durham Cluster of prisons. At the time of this research project, the Hutton Centre and later Ridgeway provided a forensic psychiatric service to the population of Teesside, County Durham and parts of North Yorkshire, a population of over 1.6 million people, from its base in Middlesbrough. This service included low and medium secure inpatient beds for adults over the age of 18 with a diagnosis of mental disorder that could include mental illness, personality disorder, learning disability or autism spectrum disorders.

The Durham Cluster of prisons includes HMP Frankland, HMP Durham, HMP/ YOI Low Newton, and the Trust also had input into HMP Holme House and HMYOI Deerbolt.

See below for a map of the area covered by the Tees, Esk & Wear Valleys NHS Foundation Trust in the North East of England:

Fig 8 Tees, Esk & Wear Valleys NHS Foundation Trust: Geographical Area, 2015.

Forensic psychiatry is a branch of psychiatry that works with people who have a mental health disorder and have had some contact with the criminal justice system. As was shown in Figure 7, chapter 1, the main risk that people referred to the service display is violence to others, but can include other offences such as arson or sexual offences.

4.5 Data Collection

The data collection pathway for this project was to be the qualitative data collected in 2 pre-study focus groups followed by 24 semi-structured interviews. The pre-study focus groups were to be held to inform the themes for some of the questions to be asked in the 24 research interviews. The focus groups were to take place in a high secure dispersal prison and with a group of community patients who had all been assessed previously by the Forensic CMHT utilising the Forensic Assessment Format.

The two focus groups were difficult to organise due to the complex nature of those involved, as well as for logistical reasons. The prison based group required a gathering of high risk mentally disordered offenders in the Healthcare centre of a high secure dispersal prison. On the day of the group, which took a lot of organising, it was decided, due to security issues, that a digital recording device could not be brought into the prison, necessitating handwritten notes being taken. This was not ideal, but a record was kept and the information gained from the group informed some of the questions used in the semi-structured interviews, see Table 1 (4.3.1.1. above). The attendees were given a selection of biscuits and cakes from Marks and Spencer's, a rare treat and a big incentive to attend. Once in the room, the three attendees readily engaged in the discussion and were pleased to be involved in a research project, expressing the feeling that they *'could have a say'*.

The second focus group had 6 service users invited to attend, all community or ward based, with the agreement that their travel expenses would be reimbursed. Unfortunately only one service user attended, but he agreed to continue and the session was recorded and generated a lot of useful input for the questions to be used in the semi-structured interviews, see Table 1 (4.3.1.1. above).

Following these discussions, the questions to be asked in the semi-structured interviews were then decided and the interviews took place with service users, Forensic CMHT staff and referrers. The initial plan to have 24 semi-structured interviews proved problematic on various levels. Gaining access to the comparator group proved challenging as there was a level of antipathy and a reluctance to set time aside for an 'outsider'. In the end, a day was agreed to do all the interviews, and the two members of staff and one service user who attended engaged fully in the process. The service user was given £20 for expenses. The second service user did not attend and it proved impossible to rearrange another interview.

The 24 interviews were reduced to 18; see Table 2 (4.3.1.1. above). Six each of service users, referrers and assessing clinicians were interviewed. I would have preferred more service users to be interviewed, but recruiting participants proved difficult, and time constraints intervened. All bar one of the interviews was recorded on a digital recording device. The exception was an interview with a referrer from a

high secure prison, which again did not allow me to bring in a digital recording device.

The 18 semi-structured interviews and the focus group and the pre-study interview were transcribed by the author, generating 59,168 words from the interviews and 3,532 words from the focus group and pre-study interview. Although this was a labour intensive effort, the knowledge gained of these data was of greater benefit than the ease of having it transcribed by others.

Descriptive data was collected in a five year period between January 2004 and December 2008 from 405 referrals that were entered onto the Forensic CMHT database. After each referral was received, a database form was filled in for entry onto the forensic CMHT database. This was stored as a Microsoft Excel File which was anonymised prior to being entered into IBM SPSS software to be converted into descriptive data charts as discussed in chapter 1.

4.6 Data Analysis: Examination and Interpretation

> *'One of the main difficulties with qualitative research is that it very rapidly generates a large cumbersome database because of its reliance on prose in the form of such media as field notes, interview transcripts, or documents',*
>
> (Bryman 2004 p399).

In this research project, the qualitative data looked to extract themes from the semi-structured interviews with the people being assessed, those involved in assessing service users and those referring people for assessment. These themes were looking at their experience of the initial assessment process.

4.6.1 Qualitative Analysis

> *'Exploration is basically a process of rearranging the data so that we can order it in some way as a device for seeing if there are any meaningful patterns in it',*
>
> (Byrne 2002 p96-7).

The focus of the qualitative data in this project comes from the focus group and 19 semi-structured interviews, and to see if there were any meaningful patterns in it, a Thematic Analysis approach was used, (Glaser and Strauss 1967), and themes were allowed to emerge from these data.

> '*The key point, in the context of grounded theory, is that our explanation or theories must emerge inductively from the information provided by our informants',*
>
> *(Polgar and Thomas 2008 p248).*

To gain the insight that allows the theory to emerge, the data should be grouped into themes, which are groups of '*ideas or meanings that emerge consistently in the text'*, (Polgar and Thomas 2008 p248). This inductive approach has been challenged by Timmermans and Tavory, (2012), who offer Abductive Analysis as a more meaningful approach for theory construction as the strength of induction does not lie in generating new theories, (2012 pp170). Polgar & Thomas also give advice on approaches to analysing qualitative data, including 'immersion' in the data; developing a coding system and identifying the themes; using those themes as a basis for insight into the respondents; interpreting the respondents experiences and ensuring the accuracy of the interpretations, (Polgar and Thomas 2008 p252). Bryman (2004 p402) suggests that:

> *'Coding is one of the most central processes in grounded theory. It entails reviewing transcripts and/ or field notes and giving labels (names) to component parts that seem to be of potential theoretical significance and/ or that appear to be particularly salient within the social worlds of those being studied'.*

One of the pillars of abductive analysis is defamiliarization, (Timmermans and Tavory 2012 pp176-7), followed by re-saturation in the data from a different perspective, such as gained by an autoethnographic approach and having *Complete Member Status* and the extra knowledge generated. As this research project was interrupted by periods of ill health lasting up to a year following data collection, periods of defamiliarization and re-saturation ensued allowing different perspectives to arise. Table 3, (Introduction to the findings chapters), notes the themes and nodes that emerged following analysis and coding of the transcribed interviews assisted by NVivo software. These can be classified as *categories*, representing real world

phenomena which contain *concepts*, which are seen as discrete phenomena, or the 'building blocks of theory', (Bryman 2004 p403).

NVivo software is part of what Bryman calls '*One of the most notable developments in qualitative research in recent years',* (Bryman 2004 p418). Computer-assisted qualitative data analysis software, CAQDAS, developed in the 1990s as noted by Lee and Fielding (1991), has since developed into, firstly NUD*IST, Non-numerical Unstructured Data Indexing Searching and Theorizing and then into QSR NUD*IST Vivo, known as NVivo. This study uses versions 9 and 10 of NVivo, available at http://www.qsrinternational.com. NVivo uses a system of coding data into nodes, which are '*items that you create to represent anything at all in or about your project, and to hold information about it, code text about it, etc.',* (Bryman 2004 p423).

The categories and nodes that developed in the thematic approach using NVivo analysis over several visits, interrupted by periods of illness, was a result of this inductive and abductive approach which led to unexpected outcomes in the results and conclusions.

4.7 Ethical Considerations

The interests of government in forensic psychiatry are channelled through the Home Office/ Department of Justice, and their priority is the protection of the public. This does not nullify the input of the Department of Health however, and when they introduced the *Care Programme Approach*, CPA, (Department of Health 1990), the management and care of psychiatric service users in the community was changed in a positive fashion, with regular, multi-disciplinary reviews and plans of care. The management and care of *restricted* forensic service users, i.e. those on Section 41 or 49 of the *Mental Health Act* (Department of Health 2008), was more effectively assessed by the issuing of a checklist by the Home Office of points they will consider when examining cases of restricted service users, (Dent 1997). The ethical considerations noted by the Home Office, are highlighted by their stated aim to '*secure individuals' rights and freedoms under the law',* (Dent 1997 p265), whilst remaining aware of the need to protect the public from serious harm. Having this dual approach of care and custody when working with mentally disordered offenders,

leads to the need for careful consideration of the ethical implications of assessment and intervention by forensic psychiatric services. There are elements of coercion and a lack of confidentiality in forensic clinical interviews, which need to be presented in an understandable and meaningful way, (Logan and Johnstone 2013 p262). On a practical level, the assessment form has a confidentiality agreement between the assessor and the assessee that the service user is asked to sign:

> **Has an explanation been given on nature and limits of this interview?**
>
> *(Forensic CMHT will not be taking over care, will make recommendations etc.)*
>
> **Yes No**
>
> I agree that the details above are accurate, and that information gained at this assessment can be used in anonymised research projects. I understand that confidentiality will be maintained within the care team.
>
> **Service Users Signature……**

When considering the ethical case for labelling someone as *mentally ill*, as opposed to seeking to resolve an area of conflict or improve coping mechanisms, for example; the ideas and thoughts of Szasz (1984) & Laing, (1960, 1967) who argued against the notion of mental illness, leads the Forensic CMHT towards a more rounded assessment of problems in people's lives, be that social injustice, economic instability, moral conflicts or relationship problems. By utilizing the Material-Discursive-Intrapsychic Model, (Ussher 2000a) adapted for forensic psychiatry and enhanced by the addition of the *BPRS*, (Overall and Gorham 1962) the *HoNOS-secure v2,* (Dickens, Sugarman et al. 2007), the assessment can cast its gaze on all areas that effect the well being of the service user, including '*intrapsychic pain, defenses, and discursive construction of madness and (gender) without privileging one above the other',* (Ussher 2000b), and also the more formal assessment of traditional signs and symptoms of mental health problems.

Ethical approval was necessary from several institutions for this research study, including Tees, Esk and Wear Valleys NHS Foundation Trust; HM Prison Service;

Durham University and the Northern & Yorkshire Research Ethics Committee. The timeline of ethical approval is set out in Appendix 10.5 on Page 276.

The process of gaining ethical approval was an iterative one, requiring the provision of information about various aspects of the study and what support structures would be in place for participants. The well being of the researcher also had to be ensured, given the level of potential risk of the client group.

The process of gaining ethical approval from the necessary bodies took over a year, with the approvals being finalised between September 2007 and February 2008.

4.8 Methodology: Summary

The experience of the informants interviewed in this study covers all aspects of forensic practice. The service users have experienced assessment by many different services in the criminal justice and health systems and, apart from the comparator group, they all have experience of being assessed using the Forensic Assessment Format. They were located in prison and healthcare institutions as well as in the community. The experiences that they bring to these interviews cover many different routes to forensic assessment including minor offences related to mental disorder to major offences resulting in several homicides. The focus group attendees have all been convicted of murder or manslaughter in the context of mental disorder. The information they supplied informed the themes that set the questions for the semi-structured interviews. The referrers interviewed had experience of working in prison, health and community settings. Some had experienced working in forensic psychiatry in the past and many had made several referrals to the Forensic CMHT over the period studied. Four were senior nurses including team managers two of which worked in the prison system; one was a social worker and one was a psychiatrist. The Forensic CMHT staff interviewed had several years experience of working in forensic psychiatry and had experienced different methods of assessment during their careers. The comparator group staff represented that services Personality Disorder and Psychosis Forensic CMHTs and both have long experience in mental health service provision, including forensic psychiatry.

The qualitative data collected during this study came from 22 different informants, 6 service users that were interviewed and 4 service users who took part in the focus group and pre-study interview, with 6 assessors and 6 referrers also interviewed. The information from the database was used to set the scene by describing the 405 service user referral episodes to the Forensic CMHT over a five year period. All the interviews were audio recorded, transcribed and then analysed using NVivo version 9/ 10 and a Thematic Analysis approach.

The themes that emerged from the data were organised into categories, see Table 3, (Introduction to the findings chapters). These categories, Assessment, Interview, Post-assessment, Approach, Social Inclusion, Forensic Issues and Staff Issues will be aligned with the research questions for the findings chapters. These themes emerged from the data using a thematic analysis approach with NVivo software providing the tool that organised the groups into nodes. Repeated analysis over several periods of time, separated by periods of ill health, allowed the nodes to be refined using an abductive as well as inductive approaches.

The implications for clinical practice of this study will reflect the outcomes of the data analysis and is discussed in chapter 9. The themes would indicate that working collaboratively with service users and taking an approach that is holistic, taking all their experiences into account and giving time for the service user to work through all the information benefits the quality of the assessment.

Of the five service users interviewed in the main study and the one from the comparator group, 3 had a diagnosis of personality disorder and 3 had a diagnosis of mental illness, which reflected well from the database of referrals to the team where these were the top two diagnosis. Four of them were male, with two female, in the database the split was 83/ 17%. The age ranges in the sample were that three were in their 30’s, one in their 40’s and one in their 50’s. The average from the database was 35 with a range of 17-89, so that fits moderately well. 33% of the sample lived in a community setting with four institutionalised, the database had 49% living in the community, so it is within limits of representativeness.

As has been stated previously, the database represents 80-90% of all those referred to the service in the period studied. This sample level presents a high likelihood of representativeness.

It was envisaged from the start of this research project that the findings would be disseminated through published articles in peer reviewed journals; prison and offender magazines and newsletters and papers presented at forensic conferences. Several papers and posters have already been presented, (Carey 2006, 2008, 2009, 2010, 2012, 2013) and a further papers will be submitted to peer reviewed journals and conferences and I propose to submit an article to *Inside Time* (http://www.insidetime.org/), in an effort to disseminate to service users in the prison system.

This is a study into how Applied Social Science can inform practice in the initial assessment process in forensic psychiatry. It is a qualitative study based in the North East of England looking at how a Forensic CMHT assesses people in hospitals, prisons and the community. By using an analytical autoethnographic approach, an understanding can develop of the three perspectives, i.e. those being assessed, those assessing and those referring which can then be analysed. Using a focus group and a pre-study interview with service users helped to set some of the themes for the questions used in the semi-structured interviews and also helped to keep the questions relevant. The use of semi structured interviews allowed new ideas to develop and were recorded and transcribed into NVivo. The sampling strategy was designed to reflect the database and team mix, with the comparator group being assigned locally. The use of a thematic approach allowed the themes and nodes to develop over time and with an iterative process which was made evident by recurrent periods of illness. Elements of abductive analysis, which creates rules from cases and results and utilises a recursive process informed the progress of the project during the latter stages.

Keeping in mind that the individual is in his present, which is constantly changing and moving to the past, described as the *emergent present* by Griffiths et al, (2010), understanding the way the informants perceive their reality was always to the fore.

In the light of the theoretical debate covering critical realist theory and this application of the material-discursive-intrapsychic model (Ussher 2000a), the methodology used in this study has produced data which can inform the current debate about how forensic assessment should be configured and applied. The initial research questions have led to new questions being asked about the process of forensic assessment and how we measure the efficacy of that assessment process.

Introduction to the Findings Chapters

In mental health settings, clinical interviews are the principal point of contact between clients and the various practitioners involved in their care...The ultimate purpose of such an engagement and any subsequent similar meetings is to understand and then do something positive to address the needs identified.

(Logan and Johnstone 2013 p259)

This chapter will introduce the findings resulting from the analysis of the qualitative data gathered from the semi-structured interviews and the focus group during this research project. It will show how the research questions outlined in chapter 3.6 were aligned with the emergent themes that developed from the NVivo analysis in association with the deductive and abductive analysis methods, as discussed in Chapter 4. These themes were reduced in each chapter to main themes and sub themes between and within each of the main groups of people interviewed as part of this research study, which were:

- Service Users
- Referrers
- Assessors
- Comparator Group

The main themes were:

- Collaboration
- Holistic Approach
- Outcomes
- Social Inclusion

The sub-themes that became apparent were:

- gender differences between service users
- prison and community location of referrers
- professional background of assessors

Using QSR NVivo versions 9 and 10, the semi structured interviews were analysed as discussed in the methods chapter. This process led to the emergence of nodes, which were grouped into the main themes shown here in Table3:

THEMES	Node 1	Node 2	Node 3	Node 4	Node 5	Node 6
ASSESSMENT	Experience of assessment	Assessment Outcome	Information prior to assessment	Previous Assessments	Assessment detail	Pre-assessment questionnaire
INTERVIEW	Length	Location	Interviewer	FAF	Miracle question	
POST-ASSESSMENT	Copy of report	Follow up review	Feedback	Suggestions	Confidentiality	Personality Disorder
APPROACH	Collaborative	Holistic	Individually Treated	Context	MDT Approach	
SOCIAL INCLUSION	Support	Service User Needs	Carer and relative Involvement	Service user view of needs	Personality disorder	
FORENSIC ISSUES	Offence issues	Risk	Substance use			
STAFF ISSUES	Qualifications	Training local teams	Report writing			

Table 3: NVivo themes and nodes

Having decided that the findings chapters should be organised by giving each research question its own chapter, the main themes, sub-themes and NVivo nodes were then aligned with the four research questions, this was an iterative process that developed over time as the analysis of the qualitative data progressed. Time spent reflecting on the data following several extended periods of illness contributed to this iterative process as the themes that emerged through deductive analysis using grounded theory and NVivo were enhanced by the abductive analysis, (Timmermans and Tavory 2012), methods described above, chapter 4.6.1. This iterative process of defamiliarization, followed by re-saturation in the data using abductive analysis, (Timmermans and Tavory 2012 pp176-7), assisted the process of aligning the findings chapters with the research questions and the themes that emerged from the data analysis.

The main themes identified for each question were primarily: Collaboration; Holistic Approach; Outcomes and Social Inclusion. The primary, secondary and tertiary themes are set out below in Table 4:

THEMES	QUESTION 1	QUESTION 2	QUESTION 3	QUESTION 4
PRIMARY	Collaboration	Holistic Approach	Outcomes	Social Inclusion
SECONDARY	Information prior to assessment	Location & Length of interview		
TERTIARY		Previous Assessments		

Table 4: Main Findings Themes

The NVivo nodes were then aligned to these main themes for each of the research questions as noted in Table 5 below:

THEMES and SUB-THEMES	QUESTION 1	QUESTION 2	QUESTION 3	QUESTION 4
COLLABORATION	Collaboration Individually Treated Context MDT Approach Interviewer Personality disorder			
INFO PRIOR TO ASSESSMENT	Pre-assessment questionnaire Information prior to assessment			
HOLISTIC APPROACH		Assessment detail Holistic FAF Miracle question		
LOCATION/ LENGTH OF ASSESSMENT		Length Location		
PREVIOUS ASSESSMENTS		Assessment Experience Previous Assessments		
OUTCOMES			Previous Outcome Copy of report Follow up review Feedback Confidentiality	
SOCIAL INCLUSION				Offence issues Risk Substance use Support Service User Needs

Table 5: NVivo Nodes and Research Question Alignment

Summary

In the next four chapters the qualitative data will be presented with each of the four research questions concerning *Collaboration, Holistic Approach, Outcomes* and *Social Inclusion* having a chapter of its own. Each chapter is split into the main themes emerging from the three respondent groups, Service Users, Referrers and Assessing staff. The perspectives of the comparator group and that of the researcher will also be given in respect of each theme.

Chapter 5

1. *Is the clinical impression gained from the initial assessment process in forensic psychiatry improved by employing the professional experience of the assessor and the personal experience of the service user collaboratively through the use of a person centred approach?*

Chapter 5 considers question 1, collaboration, and argues that the FAF, as a boundary object, improves initial assessment by encouraging communication between all the social worlds involved through the FAF acting as a boundary object and a between the service user, referrer and assessor through the use of a person centred collaborative approach, the material-discursive-intrapsychic model.

Chapter 6

2. *How does using the Forensic Assessment Format, inform the assessment process to make it more holistic?*

Chapter 6 considers question 2, and argues that the FAF is a holistic approach as it considers all the aspects and experiences of an individual and is a move away from the symptom or risk focused assessments of the past. As a boundary object, the FAF encourages communication between the different social worlds involved in the initial assessment process in forensic psychiatry.

Chapter 7

3. *What are the processes influencing outcomes for service users when using the Forensic Assessment Format?*

Chapter 7 considers question 3 and argues that the collaborative and holistic approach of the FAF leads to a comprehensive formulation of the service users needs impacting positively on outcomes. As noted previously, the purpose of a clinical interview is to '*understand and then do something positive to address the needs identified*.' (Logan and Johnstone 2013 p259). As a boundary object the FAF is shown to do this by catalysing action and meaningful collaboration among the groups involved with the service user, and the potential of the FAF as a boundary object will be released, (Rycroft-Malone, Burton et al. 2015 p85).

Chapter 8

4. *Can a collaborative approach to assessment assist the social inclusion agenda and if so how does involving forensic service users in the research process contribute to this?*

Chapter 8 considers question 4 and suggests that a socially constructed model of assessment such as the FAF can empower individuals by its collaborative and holistic approach and that this increases service user confidence and self esteem leading to greater social inclusion.

The four research questions concerning *collaboration, holistic approach, outcomes and social inclusion* in relation to the use of the Forensic Assessment Format by the Forensic Community Mental Health Team at the heart of this research project have produced several themes and sub-themes that will be analysed and the findings will be presented and discussed in the following chapters.

Chapter 5 Findings: Question 1

Is the clinical impression gained from the initial assessment process in forensic psychiatry improved by employing the professional experience of the assessor and the personal experience of the service user collaboratively through the use of a person centred approach, and if so, for what reasons?

5.1 Introduction: Is the Clinical Impression Improved?

This chapter explores themes from the 18 semi-structured interviews in response to the first research question. These data will show that the three groups involved, service users, referrers and assessors agreed that the clinical impression gained from the initial assessment process in forensic psychiatry is improved by employing the professional experience of the assessor and the personal experience of the service user collaboratively through the use of a person centred approach. The initial assessment process using the Forensic Assessment Format will be shown to encourage collaboration between the assessor and the service user as well as between the assessor and the referrer. Acting as a boundary object at a micro and meso level, this process is enhanced by input from the macro level including relatives/ carers, criminal justice, wider community support, and the education social worlds. At a micro level, the impact is on the individual service user and assessor; at a meso level, the assessing team and referring service are involved; at a macro level the service user's family, wider services of the criminal justice system, community support services and, potentially, research programmes outwith the healthcare social world could be included.

The key findings from this part of the data are that male service users felt that they had a voice and were respected, whilst female service users felt that they were not judged and were treated as an individual. The prison referrers felt that the process was in depth and gave a full history whilst the community referrers felt that the events were contextualised, inclusive and that the service user was empowered. The assessors felt that the FAF had a good structure and also treated service users individually; there were some professional differences that arose.

From my perspective as an auto-ethnographic researcher in this service, the move from the medical or general nursing models of assessment used by the forensic service in the 1990s to the material-discursive-intrapsychic model that was adapted into the FAF has improved the clinical impression gained from the initial assessment interview. The service users I have assessed using this method feel that they are treated as an individual with all the historical factors taken into account by the material section. The discursive and intrapsychic sections allow the service user to express how they interact with the world around them and what its impact is upon them. Being responsive to the needs of each service user by allowing time for them to build trust with the assessors and discover what it is that they feel about a particular concept has, I believe, benefited the assessment process. With some service users this can involve spending time exploring emotions that they have not previously accepted or understood. A key concept that emerged for service users is having the time to carry out the assessment. A general theme of having experienced time pressured assessments in the past emerged.

The assessing professionals in the Forensic CMHT who have used the FAF, now several dozen, have taken to it in various ways, usually informed by their professional background. Mental Health Professionals have been defined by Di Bailey in her book, *Interdisciplinary Working in Mental Health*, in the following way:

- *Psychiatrists who are medical doctors specialising in the treatment of mental illness using a biomedical or disease model approach to understanding signs and symptoms.*
- *Clinical Psychologists with an undergraduate degree in psychology and postdoctoral training to understand and intervene with people with psychologically based distress and dysfunction.*
- *Mental Health Social Workers who have received additional post-qualifying training with a focus on social causation and labelling as explanations for mental distress, some of whom will have completed additional training to become 'approved' to undertake statutory duties as defined by the 1983 Mental Health Act.*
- *Psychiatric nurses who specialise in a branch of nursing that provides skills in psychological therapies and the administration of psychiatric medication.*
- *Occupational Therapists who assess and treat psychological conditions using specific, purposeful activity to prevent disability and promote independence and well-being.*

(Bailey 2012 p4)

Nurses are the most positive professionals interviewed in this study and appreciate the collaborative approach and individualised methodology. Psychiatrists are more reluctant to eschew their traditional model of assessment focusing on presentation and symptoms, but they reluctantly admit that the discursive and intrapsychic elements do add a more collaborative element to the assessment process. Psychologists both agree and disagree about the benefits of using a person centred approach, such as the FAF, but would prefer an even more collaborative and individualised method. Social Workers generally appreciate the approach offered by the FAF as their profession is clearly interested in individuals and their background as well as how they fit into the world around them. Assessors also mentioned that appropriate training was necessary to understand and use this approach.

The differences within and between the groups in this study will be developed in this chapter. The different perspectives of male and female service users will be highlighted as will the different positions of the prison and community referrers. The different professional viewpoints of the assessors will also be examined in detail. The responses from these interviews, along with my personal experience, supports the statement that employing the professional experience of the assessor and the personal experience of the service user collaboratively through the use of a person centred approach such as the FAF does improve the clinical impression gained at the initial assessment stage in forensic psychiatry.

5.2 Themes

Utilizing the FAF encourages a more collaborative relationship with service users, which guides them through the difficult process of assessment whilst focusing on them as an individual, allowing more holistic outcomes to emerge, which will be discussed in the following chapters. The understanding of individuals gained from this approach, as evidenced by the data from the interviews in this chapter, puts more emphasis on why people think or act in certain ways as well as discovering what it was that they thought or did.

As discussed in the methodology chapter, themes developed through the use of abductive and inductive approaches and were organised by NVivo software using elements of grounded theory. In this chapter the themes that emerged from the first research question will be discussed. The main areas that emerged are:

- Collaboration
- Information prior to assessment

Table 6 below shows that the different groups agreed on the theme of collaboration, but that the sub-groups had differing reasons for this shared opinion.

THEME	GROUP	SUB-GROUP	DETAILS		
COLLABORATION	Service User	Male	Respected	Individual	Have a voice
		Female	Not Judged	Find out together	Individual
	Referrer	Prison	In-depth	Full History	Impact on Liberty
		Community	Service User equal partner and empowered	Events contextualised	Inclusive with Joint Working
	Assessor	Psychiatrist	Service User individually treated	Service User not equal	Background and development
		Nurse	FAF seeks a solution	Not a medical model*****	Not Q&A*****
		Psychologist	Collaboration could be better	FAF has a good structure	FAF a rounded method
		Social Worker	Service User treated individually	Good format, looks to empower	Builds trust
		Occupational Therapist*****	Formulation is individualistic	Informed consent	No tick boxes
INFORMATION PRIOR TO ASSESSMENT	Service User	2 for	Written down		
		3 against	May promote negative thoughts	Interview just questions	
	Referrer	6 for	General information	For referring staff also	Literacy level
	Assessor	6 for	Reduce anxiety	Provide information	

Table 6: Research Question 1 themes (* = Comparator Group)

The finding that all three groups agreed that the FAF allows a collaborative assessment to take place impacts mainly on two of the groups, service users and referrers. The third group, assessors, are the group that introduces the FAF methodology to the process which results in a collaborative approach. Service users are in the position of being referred for an assessment because of the perceived risk they present, and have little choice about whether or not the assessment takes place. This group can collaborate only after the fact of the assessment is accepted. The referrer group has an interest in collaborating with the assessors as they require advice and guidance on managing risk. Their commitment to collaborating with the service user group is less solid. The assessor group is committed to collaboration with both the other groups as that is seen as the best way to achieve a meaningful outcome where the risks are managed and the service user receives the most appropriate interventions to meet their needs.

The other theme to have emerged concerned *Information prior to assessment* which was generally supported by professionals as it reduced the necessity for justifying the forensic assessment in person, but less so by service users who preferred their questions and concerns being answered in person. Issues around literacy and a negative influence on the assessment also arose and will be discussed below.

5.2.1 Collaboration

Collaborative practice in healthcare occurs when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers and communities to deliver the highest quality of care across settings, (World Health Organization 2010). Collaboration in health care has been defined as health care professionals assuming complementary roles and cooperatively working together, sharing responsibility for problem-solving and making decisions to formulate and carry out plans for patient care, (Fagin 1992) and (Baggs and Schmitt 1988). Collaboration between doctors, nurses, and other health care professionals increases team members' awareness of each others' knowledge and skills, leading to continued improvement in decision making, (Christensen and Larson 1993). Bruner offered a model of interdisciplinary collaboration defined as an

effective interpersonal process that facilitates the achievement of goals that cannot be reached when individual professionals act on their own, it includes:

- *Jointly developing and agreeing to a set of common goals and directions*
- *Sharing responsibility for obtaining those goals*
- *Working together to achieve those goals, using the expertise of each collaborator*

(Bruner 1991 p6)

In this context, working together, cooperating and formulating common goals and being aware of each other's knowledge and skills are the main objectives of collaboration. The FAF can be seen as one of Leigh Stars *Standardised Form of Boundary Object* which she described as being '*devised as methods of common communication'*, (Star and Griesemer 1989 p 411), which can standardise the collection of information by different groups; in this case different professional groups and service users. Leigh Star describes boundary objects as being *'produced when sponsors, theorists and amateurs collaborate to produce representations of nature',* (Star and Griesemer 1989 p408). In this context, the representation of nature is the assessment produced using the FAF, which can be seen as a boundary object. Leigh Star also said that boundary objects are '*...both plastic enough to adapt to local needs and constraints of the several parties using them, yet robust enough to maintain a common identity across sites', (Bowker and Star 1999 p297),* in this context those needs are from referring and assessing professionals and service users. Bowker & Star later stated that *people often cannot see what they take for granted until they encounter someone who does not take it for granted,* (1999 p291). In this context, the interaction between the service users, referrers and assessors using the FAF as a boundary object has the effect of challenging preconceptions about what the processes were that led to a forensic assessment.

The level of membership to each of the groups is also fluid, (Bowker and Star 1999 p298), professionals can be subject to mental health issues and become service users in the context of offending, service users can become advocates and refer peers for assessment.

The finding that collaboration between the service user, referrer and assessor occurs is supported in this section by giving the perspectives of all those involved in the

process. The reasons why the individuals feel that the FAF is a collaborative approach are also explored.

5.2.1.1 Service Users Perspective:

The service users stated that using an assessment method that empowered them to contribute, have a voice and feel safe to speak openly was achieved by the assessment process having a non-judgemental approach, understanding their background and treating them as an individual. This included the service user taking the lead at times in the assessment, which was also seen as a supportive process. It also included being able to shape the assessment to individuals who need a more supportive and encouraging approach.

Although initially stating that he did not feel equal in assessment, Service User 2, a male prison inmate, focused on the importance of having a voice and being treated respectfully as an individual, being able to take the lead and being safe in contributing to the experience of assessment.

Interviewer So, do you think then, when I say equal partner, which I'm using to, that to get a particular…what you're seeing from that is that you're allowed to bring to the assessment what you feel is important?

SU 2: *I feel that I have a voice. I come in here, to talk to someone respectful; I can talk about anything I want to talk about, without fear of being penalised for it. Whereas, life out there on the wing, if I said to someone I'm having very violent thoughts, then they'll say "OK, you'll get an IEP, we'll take privileges off of you and we'll stop you going to work, we'll lock you in your room and we'll assess you for two weeks or put you on an App". (laughs), you can't talk about anything out there, but in here you can! You've got free reign.*

Service user 2 felt at ease to *talk about anything* in this assessment process, collaborating fully without fear of repercussions under *IEP*, Incentives & Earned Privilege Scheme (Peters 2014); or being put on an *App*, which is an application made by wing staff for an inmate to see the prison governor on a disciplinary charge. The reason that he felt that the assessment process using the FAF works is that the underlying forces acting within the prison environment are not felt to apply in this situation.

From Service User 3's perspective, a male prison inmate, being treated as an individual and having the opportunity to speak openly did lead to an accurate assessment.

Interviewer … do you feel this report reflected you as an individual, showed who you were, as an individual, not just the things you'd done?

SU 3: *It did, it's hard to describe this, because it was accurate, and at the end, the summing up did point to things that I knew helped me.*

His history includes periods of extreme and repeated violence that had led him to have experiences of crisis treatment by mental health services that generally involved medication being administered under treatment sections of the *1983 Mental Health Act*, (Department of Health 2008). The underlying process of his collaboration was that he was being seen as an *individual* by the process of assessment using the FAF rather than as a *risk* to be managed.

A comprehensive assessment, such as the FAF can also be a therapeutic process; Service User 1 a female prison inmate, felt that it allowed her to develop self-awareness, esteem and confidence. Service User 1 also felt that she was not judged and was comfortable in discussing past events.

Interviewer Was your experience that the report accurately reflected you as an individual…as opposed to reflecting you as somebody that had done something or a symptom?

SU 1: *Yeah, yeah…I mean, by yourself I wasn't judged. You know, I felt that I could go into all the things that have happened in the past with you. And…not be judged, treated as an individual.*

Her life experiences of being judged by people making assumptions about her based on her appearance and offending history led her to collaborate with this assessment using the FAF as she felt it gave her an opportunity to discuss everything that happened to her, in the understanding that this would contextualise her current situation.

The phrase, 'found out together' in this next quote from Service User 4, a female prison inmate, indicates a joint enterprise of exploration during the assessment. She had some difficulties discussing her problem areas and needed gentle encouragement and time to complete the assessment process over several sessions.

Interviewer Did you fell that you were given the opportunity to contribute to the assessment we did as a sort of an equal partner? We tried to find out together what your needs were?

SU 4: *Yeah, found out together, yeah.*

This was one of the most difficult interviews to complete as Service User 4 had experienced severe trauma in her life over a sustained period of time. The initial assessment took many sessions to build trust and establish a level of rapport. She was determined to be involved in the research interview even though she found it stressful and offered short answers. The underlying issues were about being given the space to discuss some of her past traumas in a supportive and safe environment.

5.2.1.2 Summary, Service Users Perspective:

The information gained from the interviews shows that service users have responded to the FAF approach to forensic assessment in a positive manner by the way it aims to treat them fairly and equally. The male service users feel respected, treated as an individual and that they have a voice. This need for respect reflects the social world they inhabit, male prisons, where respect is an issue on a daily basis and lack of respect can impact on psychological well being, (Butler and Drake 2007 p19). As service user 2 reflects, trust is a luxury and respect is difficult without trust:

Interviewer So it's about trust then

SU 2 *Because the majority of people in prison don't trust, don't trust anybody. It's part of the tactics, you can't afford to trust people.*

Been seen as an individual with a voice rather than an inmate to be counted and contained is reflected in their appreciation of being given an opportunity to talk and be listened to. The female service users feel that they are not judged but are treated as an individual and see the assessment as a joint enterprise. In a female prison, the culture is less confrontational than a male prison, but the way female offenders are perceived more harshly by society is reflected by their wish not to be judged or for preconceived ideas about them to be challenged, (Carlen 2013). The process of assessment is the same for each person assessed using the FAF and it is not tailored towards any particular outcome. The framework of the interview is the same

for all, but there is flexibility to expand sections to meet individual needs and time is given as needed to complete the process. This method of bridging the gap between being impersonal and treating everyone the same, whilst also treating them individually by responding to their needs has resulted in a process that fosters collaboration to gain a more comprehensive and individualised clinical impression in initial forensic assessment.

5.2.1.3 Referrers Perspective:

From the referrers' perspective, the main theme was that the service user was treated as an individual. The process was seen as collaborative by some of the referrers, both with the service user and with the referring team. They felt that the assessments were in depth and were holistic rather than looking for a set of symptoms. The referrers saw that service users could be empowered by the approach used and that this would impact on autonomy, self-esteem and confidence. One referrer noted that the service user was, to some degree, an equal partner in the process and another mentioned that the outcome of the assessment could be surprising at times. Gaining a comprehensive history of the service user was seen as a positive outcome of a forensic assessment. Collaboration between the assessor and the referrer is appreciated by the referring team, particularly when a joint assessment takes place with a referrer being involved in the forensic assessment interviews.

Referrer 1, from the prison service, perceives the assessment process from the forensic CMHT as more collaborative than assessments from other services.

Interviewer Do you think there is any difference in the collaborative element with the forensic team to assessments done by other people or other methods?

Referrer 1: *There is more opportunity to do the assessment together with the forensic mental health team, whereas other assessments are more, we ask the questions and they give the answers, it's not, we don't really work together*

Collaboration in this sense was completing the assessment with a member of the referring team present and included. They also felt that the service user was individually treated and did not focus purely on his offence.

Referrer 2, who is a prison-based senior nurse, observed that the assessments are more in depth and that the service user is treated as an individual. He appreciated the fact that the assessment included gaining a full history of the service user they referred.

Interviewer Did you feel that the service user you referred was assessed as an individual taking into account all their experiences not just focusing on events?

Referrer 2: *Yeah, absolutely, certainly very much a history of the individual; admissions, hospitals, prisons etcetera; it was a full span of all inputs.*

There was a level of agreement from Referrer 3, who is a community based consultant psychiatrist, that the service user was treated individually and as an equal during the assessment process.

Interviewer Looking at collaboration as a concept, did you find that the service user you referred was given the opportunity to contribute to the assessment process as an equal partner, with the forensic team?

Referrer 3: *I think the answer to that is broadly yes. I mean obviously it's difficult because clearly with many of the referrals they are detained under the Mental Health Act and so, in a sense, their liberty is being restricted at any rate. And, I mean obviously, any service users will probably perceive forensic psychiatry as being a restrictive option.*

The theme that a forensic assessment can also have consequences on a service users' liberty is raised in this response from referrer 3. This potential impact on liberty is one of the generative forces at play in the process of forensic assessment. A service user who is accepted into forensic services following assessment can be subject to different perceptions from those people they come into contact with including professionals, family & friends and community services. The stigma attached to being perceived as mentally disordered and a risk to others raises the threshold when decisions on discharge from formal detention under the 1983 Mental Health Act or rehabilitation into the community are being considered. A 'forensic' label may have an impact on the length of any detention, and could lead to the imposition of further restrictions when in the community or a referral to MAPPA, (Multi Agency Public Protection Arrangements) (National MAPPA Team, National Offender Management Service et al. 2012).

Referrer 5, who is a community based senior nurse, felt that the service user engaged in the process as he felt empowered and involved as an individual. She also felt that the nature of the assessment was helpful in promoting autonomy, self-

esteem and confidence and reported that she felt that because of these issues the service user was open and honest during the assessment process.

Interviewer Looking at collaboration, did you find that the service user you referred was given the opportunity to contribute to the assessment process as an equal partner?

Referrer 5: *Without doubt and I think he was very empowered by the process, and because of his personality traits, the very clear boundaries were established from the outset and he took ownership of that assessment and that assessment documentation and he shared that, and the client shared the document with a number of partnership agencies*.

That he perceived this process as respectful is reflected by his response to the boundaries that were set around behaviour, that he engaged positively with the FAF and that he appreciated being given a copy of the report which he shared with his probation worker.

Interviewer Did you feel that the report accurately reflected the service user you referred as an individual?

Referrer 5: *Again, it was very detailed and very individualised, very client centred; but also it was very...because the issues he was talking around were very sensitive, it was very respectful and presented in a way that was positive and it's enabled the client to put in perspective a number of issues and begin to move forward...*

Referrer 5 was involved in the assessment interviews with the service user and her responses point towards the assessment process being collaborative in the way that it was perceived by the service user as fair and respectful with a positive approach. The individualised element reflected that the issues important to this service user were given time to be expressed and developed at length. His considerable background in violent offending behaviour was something he wanted to move away from and he was taking part in a comprehensive assessment for the first time in order to access the interventions he needed to support him in this endeavour following a long period of incarceration.

Referrer 4, a community based consultant psychiatrist, did not agree that the service user could collaborate fully in the assessment process with forensic psychiatry due to the potential effect on his liberty if high risks were identified. He did see the assessment process as thorough and felt that other teams could, at times, see service users more as a set of symptoms.

Interviewer Looking at collaboration, did you find that the service user you referred was given the opportunity to contribute to the assessment process as an equal partner with the forensic team?

Referrer 4: *...I think that the issue is that when you refer to the forensic community team you are doing so because you are identifying that you consider that person you are referring is presenting as a risk that cannot be managed in an ordinary community mental health team and that's the reason why you are referring to forensic. Erm, in my experiences in the past, erm, the patient has not been able to fully collaborate because they have a differing opinion to what you do about the risks they are presenting...Erm, I think that other teams could be open to criticism...and that I found, in my experience that the person is not looked at as an individual, more as a set of symptoms.*

Referrer 4 again raised the issue of consequences to a forensic assessment that could impact on the service users' liberty. His opinion on collaboration in psychiatric assessment elsewhere in the interview was that *they usually don't accept that they need medication or are a risk to others*, which indicates a less than positive attitude to collaborating with service users during assessments.

Referrer 5, from a community based service, expresses positive thoughts about the assessment being a joint assessment with their service.

Interviewer How would you describe your experience of the assessment process?

Referrer 5: *Myself, I had a lot of anxieties, as a clinician, around the client and his care, 'cos I hadn't had any experience of anyone with such a serious history of violence, and I was unsure around...initially I was unsure around what the pathways would be into mental health services; how the client...how mental health services would respond to the client because of his serious history of, erm, violence. But what was excellent was that it was a, the assessment process was joint with our service and we were consulted and the client was fully consulted, which doesn't appear to happen in other secondary care mental health services.*

The collaboration between the service user, referring team and the assessors resulted in a process of consultation between the three parties involved that helped to identify the needs of the service user involved.

Referrer 6, a community based social worker, felt that the service user was, to some degree, an equal partner in the assessment process and was treated as an individual, compared to other assessment processes, which he saw as less equal and individually focussed.

Interviewer Did you feel that the service user you referred was given the opportunity to contribute to the assessment process as an equal partner... with the forensic team?

Referrer 6: *I feel definitely, I think definitely he's had the opportunity; I wouldn't like to gauge that as a percentage...'cos obviously there is two key issues which, in this case, which*

need primarily focused; but obviously his mental health needs were very much part of that, ... the, er, nature of the offences of this service user...

Referrer 6 is again aware that there are several elements to a forensic assessment and identified two main areas of focus, mental health and risk. That this assessment was completed using a process that looks to treat the service user as an equal partner was also noted.

5.2.1.4 Summary, Referrers Perspective

The referrers in this study generally felt that the forensic assessments using the FAF were comprehensive and provided useful information, such as a comprehensive history. The prison based referrers stated that they appreciated that the FAF provided an in-depth assessment that provided them with a full history. They expressed some concerns about the impact on the service users' liberty, reflecting the fact that the majority of people in prison have a release date; where as those detained under a MHA1983 section have no set discharge date. The community referrers stated that the service users were assessed as an equal partner and could be empowered by the FAF assessment process. They also mentioned that events were contextualised due to the comprehensive nature of the assessment. They also appreciated the opportunity to joint work with the forensic service and felt included in the assessment process. A majority of referrers felt that there was collaboration with service users built on fairness and respect but that an underlying element of a potential risk to personal liberty impaired the service user to some extent throughout the process. The collaboration between the referring team and the assessors helps to build a fuller picture of the service user being assessed. Part of this process will be a professionals meeting prior to the assessment to discuss if the service user meets the criteria for a full assessment. Occasionally, a referring team is seeking confirmation that they have assessed risks and identified needs, and that may not necessitate a full forensic assessment. Building professional relationships by collaborative working practices during the referral, assessment and intervention elements will increase the likelihood of reducing risks. The underlying theme was of needing a thorough assessment of risk and mental health with practical advice on management strategies.

As shown in table 6, (see 5.2), the focus of prison and community based referrals are different. The prison referrers are more likely to want to access appropriate mental health care for service users based within the healthcare centre of the prison, where access to high quality psychiatric care is not readily available 24 hours a day. A thorough assessment by forensic services can mediate this outcome, if it is indicated. Their service users are not a risk to the general community as a result of their detention. The community based referrers are more likely to be looking for help in managing service users' they perceive as a risk to others in the community. At times, they may want forensic services to take over the care of the service user they are referring; in other cases they may want support and advice through a period of joint working following assessment.

5.2.1.5 Assessors Perspective:

The assessors from the Forensic CMHT felt that the process using the FAF gave a rounded assessment of the individual not just focusing on the problems and risks presented by the service user being assessed. Taking into account the background and development of the service user was seen as important by two members of the assessing team. The social worker felt that building trust with less difficult demographic questions prior to asking about offending and risk was beneficial. He also highlighted the *forensic* element of the assessment and potential consequences. The assessment process being individualised was helpful with asking about cultural elements being highlighted. The psychologist and psychiatrist expressed some concerns about the assessment being individual, collaborative or equal for the service user. They did however accept that they felt that the process used did allow them to individualise the service user in the report and that taking a comprehensive history helped to individualise the service user generally. The comparator staff felt that their assessment, although a long process lasting up to twelve months, was individualistic and respectful. They highlighted the quality of the relationship that could develop in this time scale leading to a collaborative and individualised service. They pointed out the importance of support from the local

team for the service user during this assessment process. They also felt that there was a dual responsibility to the referrer as well as to the service user.

Assessor 1, a psychologist, has a dichotomy in his responses; he states that he tries to write his report in relation to the individual service users' needs but does not always see them in that rounded way. He then states that the model used, the FAF, is structured to give a more rounded assessment of the individual not just the problem or risk and that the level of assessment of background and development contributes to this. He also states that service users are not always seen as individuals or assessed in a collaborative manner.

Interviewer Think about one assessment, did you feel that report accurately reflected the service user you assessed as an individual, as opposed to, for instance, an offender or somebody at risk to others?

Assessor 1: *Erm…I always try to make my reports, no matter what the structure of them, relevant to that person as an individual. …I try not to lose sight of the fact it's about that individual's needs, so I always try to reflect that in the structure of how I'm assessing things now and reporting back.*

Assessor 1 focuses on the micro element of the individual and is assisted by the FAF in achieving his need to collaborate to some extent. The bridge between the impersonal fairness of the same approach being used with all service users and the individualised assessment allowed by the same interview schedule offered by the FAF allows him to make some progress towards a collaborative assessment. As a boundary object, as defined above, the FAF is accessible to the different people using it such as this psychologist. He focuses on the individual service user's needs and the structure provided by the FAF allows him to develop those areas he feels are important. He can then interpret this information to formulate his findings with his assessing partner in the resulting report. The service user he is assessing will be able to use the FAF to express his needs through his responses to the various sections. As a boundary object, the FAF is accessible from the different groups it is used by in ways that each group and subgroup require.

Treating people as an individual means giving them the opportunity to discuss their history and actively listening to what they have to say. Assessor 2, a social worker, feels that by starting with demographic and historical information trust can be built that will ease the later discussion concerning risks and offending. Having a set

format, such as the FAF, helps to ensure that the assessment process is the same for each person assessed. He also notes that the assessors need to be aware of the effect that a *forensic* assessment can have on people; that it may result in formal detention.

Interviewer Looking at collaboration, did you find that the service users you have assessed were given the opportunity to contribute to the assessment process as an equal partner?

Assessor 2: *I think we are always, at least I hope in the assessments I do with others we always give them that opportunity. As to whether people always feel empowered enough to feel an equal partner in an assessment process is a different matter. We can use the language, but it doesn't change the fact that you're sat in front of two people with Forensic attached to their names or professional badges; and I'm sure for some people that puts the fear of God into them. 'What's going to happen to me next?' 'Am I going to be whisked away to some medium secure or secure unit?' And I think there is an element of anxiety for some; others obviously don't give a monkey, one way or another. ... But yea…I think there's a natural level of disempowerment with any interview with professionals. I think you always have to overcome that, and having a set format, that reassures people that it's the same for everybody else and they have a chance to feedback and you always leave spaces for them, but…*

Interviewer Do you think that's different in our team to other teams you have worked with; that level of collaboration or fairness in getting the same assessment each time? Although they are quite different things aren't they?

Assessor 2: *Yeah, I think that wherever you go, there is always that aspiration to empower and to make people part of the process. So, I wouldn't put our team on a pedestal, but I think that the whole structured format does support that feeling on the service user behalf that this isn't something unusual, something we do each time is honed, it's professional and it's been done for a reason.*

Assessor 2 links two of the themes already highlighted, that a forensic assessment can have an impact on liberty and that the FAF gives some reassurance that the process is the same for everyone and will be fair and seeks to empower the service user by using an inclusive approach. The *natural level of disempowerment* noted by assessor 2 above is usually an element that impacts on interactions between professionals and service users. During interactions with forensic services, that disempowerment can be heightened as service users may perceive that a forensic assessment will often result in detention. This is not supported by the data collected on assessment outcomes during this study that showed that only 6 out of 405 community forensic referrals over a five year period resulted in an admission to forensic inpatient services, (Carey 2009). In the second answer, assessor 2 gives further support to the FAF being a boundary object when he links the structured format to supporting the service users understanding that the FAF is not something unusual, only being applied to him or her, but that it is applied in all assessments.

The service user is individualised in the report summary by Assessor 3, a consultant forensic psychiatrist, which includes '*that sort of stuff*'. Background and development is seen as important to understand current presentation, given the time. He found it difficult to envisage the assessment as equal or collaborative.

Interviewer Did you feel that the report accurately reflected the service user you assessed as an individual?

Assessor 3: *Well, with the proviso that those sort of questions that talk about aspirations and, erm, defence mechanisms, and expectations and stuff; all sort of personal stuff tends to occur at the end when the energy levels are low...it's very difficult for them to be an equal partner. I think that that's…in a perfect lovey dovey world, where you've got somebody whose functioning well and he's insightful, etc., etc., ...the idea of having a collaborative, erm…event, is just pie in the sky frankly, it's not going to happen is it?*

Assessor 3 is used to working with a medical model of assessment that considers the material aspects of a service user's life. He would assess history, presentation, symptoms and offending. The discursive and intrapsychic elements of the FAF assessment, *that sort of stuff*, provided a new insight for him. He finds that collaboration can be impaired by the level of cognitive functioning of the service user. It may be that assessor 3 sees the *individual* element of the service users he is assessing as more related to the medical model of a history and a set of symptoms and risks rather than the holistic individual envisaged by this model that includes all of the aspects, experiences and interactional styles that makes them who they are.

Assessor 4, a nurse, thought that finding a solution was more important than responding to the potential risk that generated the referral.

Interviewer So, do you find that with the forensic assessment format, people will collaborate to get the assessment, or do you think that it's still an assessment done to the patient?

Assessor 4: *I think it depends on who generated and why the referral was generated. Just so that you desperately want a solution, as opposed to, it is done to them because of an event or a risk that has been identified for them…*

Having this solution focused approach can be enhanced by having a formatted approach such as the FAF which does not purely focus on risk assessment. At times referrers require an 'answer' to their 'problem' which preferably, from their perspective, includes someone else taking responsibility for the service user and their assessed risk. By looking at all the generative forces underlying the risk and

offering a way of understanding and responding to the risk, and its genesis, more lasting solutions can be formulated using the FAF.

5.2.1.6 Summary, Assessors Perspective:

A majority of the assessors did state that the FAF provided a collaborative approach to assessment, that it can be solution focussed without purely targeting risk. The difference occurs when considering the macro impersonality of using an interview schedule where all the assessments ask the same basic questions, whilst the micro element of individualised assessment is allowed by the flexible approach of a semi-structured interview schedule which can be steered by the service user or the assessor to inform the narrative. One of the generative forces that can be a theme of any forensic assessment is the impact on the service users' liberty, and this was raised several times as a perceived consequence of being assessed by a community forensic service. That the risk of being detaining by forensic services following an assessment in the five years of this study was around 1.5% which does not support this as a potential outcome. This returns us to the definition of collaboration, working together or cooperating with the enemy; with the FAF as a boundary object that has *'arise(n) over time from durable cooperation among communities of practice',* (Bowker and Star 1999 p297), which it inhabits, the service user can be perceived as working together, cooperating with the assessors and accessing the FAF from their own perspective. That the FAF is the same for all the service users' assessed using it was seen as a positive, even if some elements can be a little *pie in the sky*.

As a *boundary object*, the FAF provides bridges for the assessors to access information from all the *social worlds* that it inhabits when completing the assessment. This can include gaining information from criminal justice, social care, relatives and community services to inform the process, which all the assessors appreciated. Once completed, the FAF report can then inform these different social worlds with specific information about, for example, housing or employment needs.

The different professional agendas among the assessors give a dynamic that challenges the assessment and is the reason why assessors from two different

professions complete each assessment. The psychiatrist has a viewpoint that can focus on the medical model that places importance on diagnosis and symptoms as well as medical interventions to treat them. The psychologist will place importance on background and development of psychological issues and potential interventions to address them. The social worker will be interested in family and relationship issues, as well as the practicalities of housing, benefits and employment. The nurse will be focussed on assessing the care needs of the service user, looking at issues around collaborating and supporting the service user, their carers' and the local team.

5.2.1.7 Comparator Group Perspective:

The comparator group, from a neighbouring NHS Trust, have a different way of working, using a nationally set assessment process that uses a mixture of Structured Professional Judgement and actuarial risk assessment guidelines.

Service user 6, a male in his 50's, from the comparator group, agreed that he felt like a 'person' during the assessment process using standard forensic assessment guidelines, and that he saw this assessment as being assessed as a grown up.

Interviewer When you were assessed here with this team, do you feel you were given the opportunity to contribute as an equal partner in the assessment, rather than having it done to you, if you know what I mean?

SU 6: *Yeah, I didn't feel like a student, or something, I felt like a grown up, a person...it's only like the last year or something that I've actually been able to get the things out that I've wanted to get out; things that's on me head, things that are troubling us, things I've only just been able to admit to meself, you know what I mean, for a long time I didn't want te, yah nah, I've got problems and stuff, and...*

The assessment process from his current team has differed from his previous experiences where he was not encouraged to discuss what was behind his violent behaviours and fantasies. With his current assessment, he felt that he was treated with respect, as an individual.

The assessors from the comparator group expressed the opinion that their assessments, which are a selection of formal assessment guidelines as detailed

below, can take a year to complete, are individualistic and respectful. Assessor 5, an Occupational Therapist, also feels that they are collaborative with the service user and that support outside of the assessment process is helpful for the service user. She is also aware of her dual responsibility to the referrer as well as the service user. The prescriptive nature of their assessment method which utilizes *HCR20*, *IPDE* and *PCL-r* assessment guidelines (see chapter 2.3.6) which look at risk, personality disorder and psychopathy respectively can be restrictive in encompassing an assessment that is focussed on the individual as an equal partner in a collaborative assessment.

Interviewer I guess this follows on from other questions, but I'm thinking, in particular, of other people you have assessed, do you feel that the report accurately reflect the service user you assessed as an individual?

Assessor 5: *Yeah, erm...yeah I think it does, the write up of the assessments can be quite prescriptive, yeah. We are looking at the HCR20 risks, you're looking at the psychopathy effects, you're looking at the IPDE categories. But we have that at the formulation at the end, the formulation is quite diagrammatic of what this persons early experiences were, what behaviours are problematic for them, what, you know, the recommendations I think, the history's at the start and a bit at the end, I think it's very individualistic...There's aspects of it that feel very collaborative and that we feel we share information, but I still sometimes think about our, the dual role, the dual role we have and why we are using that information as well.*

Although she feels that it is to some extent collaborative, the underlying thought is that the assessment is for the referrer, and if it can be person centred at times, that's a bonus. This dual role, deciding whether they are they working for the referrer or the service user, is a difficult contradiction at times given the prescriptive nature of the assessment guidelines they use.

Assessor 6, a Nurse from the comparator group feels that the quality of the relationship is important, and that treating a service user as an individual can be meaningful to them. His experience is of a more medical model, looking to gain answers to questions from history taking interviews.

Interviewer How about collaboration, which is a big part of this, did you find that the service users you have assessed were given the opportunity to contribute to the assessment process as an equal partner?

Assessor 6: *Erm...I suppose I've seen it from both point of views, I suppose...erm...probably where, erm, assessments are more, erm, medically model-led, where it's very much a case of taking histories, it's very much question and answer, you feel really that, erm, the patient has very little input in terms of how that assessment is structured.*

Again, assessor 6 does not feel that the assessment process he has experienced allows full collaboration with the service user, focussing on the benefits of a positive outcome from their comprehensive and intensive assessments which can take many months to complete. Where the service user is simply subject to a question and answer session to gain a history and elicit any symptoms in an effort to formulate a diagnosis, collaboration and contributing as an equal partner will be compromised. There is little evidence that their assessment process is able to act as a boundary object between the different groups and subgroups involved.

5.2.1.8 Summary, Comparator Group Perspective:

The comparator group differs from the forensic CMHT, who are the focus of this study, in that their assessments are completed using the national dataset for the assessment of personality disordered offenders, which uses the HCR20, IPDE and PCL-r assessment guidelines. Although providing an assessment process that is the same for all the service users they see, it is a process that has its foundation in diagnosis and risk assessment and that it provides a service for the referrer with any benefits for the service user resulting from that focus.

5.2.1.9 Jon's perspective: Collaboration

When I was introduced to Jane Ussher's book chapter in 2000/1, (Ussher 2000a) during my undergraduate degree at Teesside University, the pieces of a jigsaw started to fit into place and a method of forensic assessment that considered all aspects of an individual in a collaborative manner emerged. I subsequently developed an assessment guideline for forensic CPN's to use during prison sessions in the Durham cluster of prisons, the first Forensic Assessment Format. This was the focus of my dissertation at Teesside University, *Towards a Forensic CPN assessment tool: critical realism in practice*. Over the next few years the FAF was used by CPN's in the local prisons as an assessment guideline. By 2003, when the forensic CMHT was being redesigned into a multidisciplinary service for launch in 2004, the FAF had been in use for 2 years and had evolved in response to

suggestions from staff and referrers. I suggested that a multidisciplinary version could be developed that would provide a consistent assessment process for the team. This involved working with all the professionals in the new team, medical, psychology, social work and nursing, to agree a format that they could all use. Over a period of 6 months, discussion with team members led to the version of the FAF that would be trialled for 6 month prior to an audit of those staff using it.

The agreement of nurses and social workers was relatively straightforward. Nurses had experience of using the FAF in the prisons and social workers suggested an extended section on social elements, including child protection issues. Psychology staff asked for more thought around psychometrics, but agreed that post initial assessment was a better time to consider psychometrics, such as those assessing personality or intelligence. The two psychiatrists on the team, whilst supporting the concept of a common assessment format, had a reluctance to move away from their medical model of assessment. Repeated discussions and negotiations took place to arrive at the final version of the FAF. During this period, I had to defend the use of the MDI model and particularly the discursive and intrapsychic aspects. Team members felt that these elements were difficult concepts to understand and wanted to concentrate on the material aspects, as would usually be done. As noted in this chapter, the use of the MDI model has led to a collaborative method of assessment that would be less without the discursive and intrapsychic aspects. As the protagonist in this enterprise, I feel justified in standing by the model used and that by asking questions about how the individual fits into the world and what its effect is on them, a more collaborative assessment environment is created. Indeed following an assessment with one of the psychiatrists, they highlighted that the service user had responded well to the question in the discursive aspects section concerning the difference between aspirations and expectations and how that could impact on a problem solving approach, in this service users case to gain qualifications to achieve his aspiration for future employment.

Utilizing the FAF encourages a more collaborative relationship with service users, which guides them through the difficult process of assessment whilst focusing on them as an individual, allowing more holistic outcomes to emerge. The understanding of individuals gained from this approach, in my experience, puts more emphasis on why people think or act in certain ways as well as discovering what it was that they thought or did. Between 2006 and 2008, I noted that collaboration between professionals, involvement of service users and a focus on interdisciplinarity were developing themes within the forensic CMHT following the introduction of the FAF. These developments led me to encourage professionals from the forensic CMHT to present a seminar at the IAFMHS, (International Association of Forensic Mental Health Services), conference in Edinburgh in 2009,

Using a Shared Care Model in a Forensic CMHT, (Carey, Jones et al. 2009). One of the features of developing the FAF was that it became a team building process allowing members to open lines of communication, even if that was to agree that the *material-discursive-intrapsychic model* is a bit of a mouthful.

I completed the audit of the usefulness of the Forensic Assessment Format in April 2005, by gaining feedback from the multi-disciplinary team. This audit consisted of a 32-point questionnaire and formal feedback. At that point, the format had completed a 6-month trial as a Multi-disciplinary Team assessment tool. The audit found a positive attitude to the FAF after the initial 6 month trial, with all the assessors using it agreeing that the FAF is *'a valuable assessment tool for the forensic CMHT'*.

Over the next few years, as this approach developed, expectations from referrers increased and the team felt more pressured to provide comprehensive feedback, which impacted on time management. In 2007 I noted that the study aimed to move the service user from being a passive recipient to someone having active involvement. In 2010, Bowker & Star were introduced recognising the link between Ussher's MDI model and the Boundary Object principle in the FAF for the first time. The different iterations of the FAF, leading to the version used in this study, were developed with the forensic CMHT staff, service users and referrers. The Audit described above was the start of a process that looked at the running order of the interview, which other structured assessment to include and which to exclude. This process was iterative in nature and involved discussions with, and experience of working with, other forensic CMHT members, service users and referrers as well as people from the CJS, voluntary agencies, housing as well as carers and family members. This process involved incorporating the Global Assessment Scale, (Endicott, Spitzer et al. 1976) for a period of time. Following a decision by the Forensic Directorate that the HoNOS-secure, (Dickens, Sugarman et al. 2007), would be required to be completed with all referrals, the GAS was dropped due to a perceived overlap. As has been noted, the HoNOS-secure was not popular within the forensic CMHT and a subsequent study found that it could be inconsistent, (Tiffin, Carey et al. 2011). The BPRS, (Overall and Gorham 1962) continued as part of the FAF throughout its use with the forensic CMHT.

Other elements of collaborative work not apparent in these interviews are the involvement of services outside of the Health sphere. The criminal justice system, police, probation, prison staff, MAPPA, MARAC; voluntary agencies, such as MIND, housing providers, day services; Social Services including adult & child protection services and especially family and carers. Developing improved links with these services and individuals through the use of the FAF, which requires that all information is sourced to inform a collaborative assessment, has led to improved working practices and communication. Leigh Star's boundary object principle not only impacts on communication between secondary and tertiary mental health services and service users, but also on interdisciplinary communication between all the services and individuals noted above. An example of which would be the chair of a local MAPPA meeting asking for advice on communicating with other agencies to achieve an outcome seen as beneficial for the service user being assessed. This was done by involving other agencies, such as commissioners, housing and social services in gathering information to inform the FAF assessment. They gained more ownership of this task and were therefore more willing to see a positive outcome. The result of this improved communication was an out of area placement in a specialist brain injury service for the service user.

My perspective of the FAF as a collaborative assessment process remains as clear as when I first read Jane Ussher's chapter in 2000, it is the final piece of a jigsaw that completes my vision of the assessment process as a collaborative enterprise.

5.2.2 Information Prior to assessment

A majority of people interviewed felt that providing information for the service user prior to the assessment was a good idea. The professionals were positive that some information about the assessment prior to interview would be useful; service users were split in their level of support.

5.2.2.1 Service User Perspective:

Service users 4 and 5 felt that it would be a good idea to have information prior to assessment but service user 1 was more ambivalent. Service user 2 did not want information prior to assessment as he felt he might become upset at the issues this might raise prior to having access to professional support. Service user 3 did not see the point of receiving information prior to the assessment.

It is interesting to note that service users 2 and 3 are male service users detained in a dispersal prison on life sentences and service users 1 and 4 are female and detained in a local prison on determinate sentences. The paranoid thought processes evident in service users 2 and 3 may influence their opinions against having information prior to the assessment, as long term prison inmates, they understand that they will have time to *ponder/ mull over* the information with little opportunity to have support from family, friends or professionals to discuss the content. Service users 1 and 4 have access to support networks on their wing, both from staff and other inmates. Service user 5 is a community based service user with a mental illness diagnosis who had 24 hour access to professional support and he could also access family support. It would seem that having someone to go through the information provided is seen as a positive element.

5.2.2.2 Referrers Perspective:

All of the referrers felt that information prior to the assessment would be helpful with one referrer feeling that literacy levels would need to be taken into account.

Interviewer: Would information given to the service user about the assessment prior to the appointment have been helpful?

Referrer 4: *Yes, absolutely because ...to have something that is client friendly from the forensic team that you can give out would be absolutely fantastic. ...just a letter with the name Forensic Community Mental Health Team, is probably a bit scary.*

The referrers support for information prior to assessment reflects their wish for the assessment to progress and their opinion that the service users may be reluctant to engage with the forensic service which may be perceived as *scary* by them.

5.2.2.3 Assessors Perspective:

All of the assessors felt that information prior to the assessment would be helpful in reducing anxiety levels about the assessment process and what the forensic team can offer.

Interviewer: Should the service user have more detailed information, prior to the assessment, of the process involved?

Assessor 2: *I think that gets back to my earlier point that sometimes you think that people are unprepared or unsure, nervous, anxious about the whole process; but you can't get rid of that in all cases, but I do get the sense for a lot of cases that they have just been told they have been referred, they're going to come and see you on this date.*

The assessors' opinion that it would be useful to provide information to service users prior to assessment reflects their experience that service users may be unprepared or even unaware that they have been referred for a forensic assessment. By being provided with more information on the process, an element of collaboration may begin to be encouraged.

5.2.2.4 Comparator Group Perspective:

The comparator group assessors' both agreed that information prior to assessment is beneficial. The service user from the comparator group did not agree.

Interviewer Should the service user have more detailed information, prior to the assessment, of the process involved, or do you already provide that?

Assessor 5: *I think we provide it. We send them a letter and a leaflet which talks about the service and what it is ...but we don't do that in writing either, so, again, I think it might be helpful to say what the IPDE is, what the psychopathy checklist is and letting them know actually, exactly what they will be doing.*

Again, the experience of the assessors is that if a service user is prepared and understands what the process is, the assessment will progress positively. The service user, with diagnosis of mental illness and personality disorder disagreed as he sees the assessment process as simply agreeing to answer questions honestly.

5.2.2.5 Jon's perspective: Information prior to assessment

For a service user, a referral to the forensic CMHT can be a frightening experience, the potential impact on their liberty of an assessment by '*forensic services'* may have been communicated to them by their peers. Prior to this study, it was not unusual to arrive at an assessment and discover that the service user had no knowledge that the assessment was planned. Information about the assessment should be provided verbally to the service user by the referrer. This can be a difficult process as service users may be reluctant to engage. Although providing leaflets can be helpful, talking with the service user is always more effective at answering specific concerns or queries. Levels of literacy are sometimes misunderstood by staff, and service users can hide their levels of understanding, wishing to appear more able in difficult circumstances.

An example from my clinical work is of a service user being provided with a leaflet concerning the forensic CMHT and the assessment process by ward staff. This was then recorded in the patient record system as the service user had 'been given and had read the leaflet' where, in fact, they had not read it due to literacy issues. When the assessment took place, the service user was immediately shocked and reluctant to engage until the process had been carefully explained. I think it is important to remember that, as an assessor, I have experienced many forensic assessments over several decades, whilst for each service user; this may be their first and could be an anxious and difficult experience which they may feel could impact on their liberty.

The other element of this theme is information gathering by the assessor prior to assessment. I find that the FAF can be informed by gathering information from patient records as well as information from other services, such as the Criminal Justice System, Social Services, voluntary agencies, housing and family and carers. My experience and that of my colleagues is that the sectional layout of the FAF allows information to be incorporated prior to the assessment interview(s). This can then be corroborated at the assessment and can also save repeated assessment of historical information.

5.2.2.6 Summary, Information Prior to Assessment:

It is interesting to consider the differences between the groups in this theme. The professionals are overwhelmingly in support of providing information to service users prior to assessment. Is this generated from a wish to facilitate the completion of the assessment process using whatever they feel will work? Experience shows that service users rarely give written information, in the form of leaflets and letters of explanation, much credence preferring to have the process explained and any questions they have answered. Offering written information prior to assessment is easier for professionals than having to justify why a forensic assessment has been requested. Service users prefer an open and honest conversation that respects their ability to engage in a discussion about their perceived risks and needs.

5.3 Summary: Why is the clinical impression improved?

Is the clinical impression gained from the initial assessment process in forensic psychiatry improved by employing the professional experience of the assessor and the personal experience of the service user collaboratively through the use of a person centred approach, and if so for what reasons?

The findings in this chapter show that the Forensic Assessment Format, (FAF), utilising the material-discursive-intrapsychic model suggested by Jane Ussher, (2000a) and adapted by the author, (Bailey 2012 pp161-164) does improve the clinical impression gained from the initial assessment process by encouraging a collaborative approach. The different sections of the FAF allow an individualised clinical impression to develop as the service user is given the opportunity to articulate their perspective; which leads to the clinical impression being improved as the service user is involved as an equal partner and can be perceived as such by the referrer and assessing clinicians. That a person centred approach, the Forensic Assessment Format, has improved the clinical impression gained from the initial assessment by creating a more collaborative assessment process is supported by all

three of the groups involved in this research project agree with this statement, but for different reasons as noted below.

Service users stated that they have a voice when using this approach to the assessment process and felt safe to talk openly as it was seen as non-judgemental and treated them as an individual. They noted that being able to take the lead in the process allowed them to collaborate on a more equal footing. The service users felt that they were treated as an individual, with the female service users stating that they were not judged and that they found out about themselves with the assessor. The male service users felt that they had a voice and were respected. They all perceived it as fair and the same for everyone and that it is a safe process.

The main issues raised by the referrers were the individual nature of this assessment process and the need for information to be provided prior to assessment for the service user. They also felt that service users could be empowered by the FAF approach and were treated as an equal partner to some extent. They appreciated the level of detail in the report generated by the assessment and felt that the report was holistic and not focusing purely on a set of symptoms. Referrers noted that service users could be empowered by the person centred approach utilised by the FAF which impacted on autonomy, self-esteem and confidence. The prison referrers liked the in-depth history that resulted from the assessment whilst the community referrers felt that the service users were treated as equal partners and events were contextualised. The community referrers also felt included in the assessment and appreciated the joint working element. Although seen as a fair and respectful process, the potential consequences on the service users' liberty was seen as one of the negative generative forces underlying the assessment process.

The assessors felt that the FAF gave a rounded assessment that did not focus purely on the risk and offending elements. The individualised nature of the assessment developed as a theme. The running order of the assessment, with demographics at the start, leading into history prior to discussing risk and offending, was seen as a way of understanding the individual prior to considering those elements. This approach allows collaboration to develop and for the process to be more person centred encouraging trust to grow between the assessors and the

service user. The assessors had different views that could be seen as being based on professional viewpoints. The psychiatrist could not see the service user as collaborating, but did see them as being treated as an individual and having all their background and development taken into account. The nurse felt that the FAF was looking for a solution rather than focusing on problems. The psychologist felt that it is difficult to have a purely collaborative assessment, but that the FAF had a good structure and was a rounded method that sought to collaborate. The social worker felt that the service user was treated as an individual and that the FAF was a good format that looked to empower and build trust with the service user. The assessors felt that the running order of the FAF allowed a process of collaboration to develop through the assessment process. This individualised micro element balanced the impersonal macro element that a fixed interview schedule, the FAF, can be seen as. From the assessors' perspective, the FAF generates a process that builds towards a full and rounded assessment that looks to find solutions in a collaborative manner.

The comparator staff felt that their assessment could build trusting relationships as the process they use can take up to twelve months. They felt that this led to a more collaborative and individualistic service. They mentioned that they felt a dual responsibility to the service user and the referring service equally and that the service user needed support from the referring service during the assessment process. The comparator group assessors felt that not using a medical model, purely questions and answers or tick boxes helped to make assessment more collaborative. The occupational therapist from that group stated that formulation and informed consent were also important. That the assessment process took up to twelve months to complete in this group leads to the assumption that a more therapeutic intervention than assessment was in play and that the trust they discuss is a result of that rather than the assessment methods they use.

Although each group agreed that the process was collaborative, the service users felt that this was achieved through a respectful and non-judgemental approach in which they had an active not passive role; the referrers wanted an in-depth report and to be involved in the process, whilst the assessors felt that the FAF provided a good format that provided an individual solution seeking approach.

The issue of information prior to assessment was supported by the professionals, but only to some extent by the service users. Too much detail on the potential outcomes of a forensic assessment could promote anxiety for service users whose liberty may be at risk. The underlying forces acting on this process could involve the professionals' reluctance to engage in a conversation about the need for a forensic assessment and to answer the concerns that service users may express.

Initial assessment in forensic psychiatry can impact in differing ways on those assessed, those assessing and those referring for assessments. The use of a person centred approach as offered by the Forensic Assessment Format has been shown to offer a collaborative method of assessment that is appreciated by each of these groups. That the FAF provides a *method of common communication across dispersed work groups*, (Star and Griesemer 1989 p411), by being accessed by service users, referrers and assessors with different generative forces at play as noted above; the FAF is a *standardized form* of a boundary object as defined by Star and Griesemer, (1989 p411). The FAF acts as a temporary bridge between service users, referrers and assessors in collaboratively gathering, recording and presenting information during the initial forensic assessment process. Within and between each of these groups, the bridges provided by the FAF act as *boundary objects* that encourages positive steps forward to be taken. The different professions can meet and agree on a process of multidisciplinary assessment that retains their professional objectives, but adds nuances that improve the process. Service users can be respected (males) and not judged (females) whilst being treated as an individual because the FAF does act collaboratively with them to achieve common goals. Referrers in the prison system can get there in depth history whilst those in the community enjoy joint working and having events contextualised by the FAF process. The FAF looks at why people act not just what they did.

Adapting the material-discursive-intrapsychic model of critical realism into an assessment guideline, the Forensic Assessment Format, has created a boundary object that achieves its objective of collaborative assessment by challenging previous models that developed prior to the emergence of the multi-disciplinary team in forensic mental health.

Chapter 6 Findings: Question 2

How does using an assessment guideline, the Forensic Assessment Format, inform the assessment process to make it more holistic?

6.1 Introduction: Is the FAF more holistic?

This chapter explores themes from the 18 semi-structured interviews in response to the second research question looking at how the FAF informs the assessment process to make it more holistic. As noted in the literature review chapters above, there have been two main areas of development that have impacted forensic psychiatry over the past few decades, changes in *Risk Assessment and Management* and the rise of *Service User Involvement/ Empowerment* in mental health services which have led to a move towards a more holistic approach to assessment in psychiatry. This chapter will show how the FAF improves the holistic nature of the assessment process by its application of the material-discursive-intrapsychic model which looks to connect all aspects of the individual being assessed without privileging one element above another. In this context, the NHS Improving Quality document concerning Holistic Common Assessment defines the benefits of a holistic approach as helping by:

> *...creating opportunities for the individual to consider, alongside those involved in their care, all aspects affecting their life, and to identify and articulate their needs and priorities. It helps put that individual in control, while prompting other agencies to take action when required.*
>
> *(Richardson 2010 p3)*

From my perspective as an auto-ethnographic researcher in this service, achieving a more holistic approach to assessment has been achieved through introducing a collaborative and holistic model of assessment that considers all aspects of service users', identifies their needs and prompts all agencies involved to formulate interventions to meet those needs in partnership with the service user.

The two main themes that emerged from the analysis of these data were that the FAF process is holistic and that consideration of the length and location of the assessment was important.

In the previous chapter the FAF was shown to act as a boundary object, (Star and Griesemer 1989), and its ability to be accessed by all the professionals involved, as well as empowering service users to participate collaboratively, increases its ability to encourage a holistic approach to initial assessment in forensic psychiatry.

6.2 Themes:

The main theme that emerged from the 18 semi-structured interviews in response to this question was that the FAF is holistic in its approach, looking at the whole person, taking into account mental health and social factors, rather than just focussing on the symptoms of an illness, disorder or an event.

Male service users felt that the assessment process using the FAF was comprehensive, safe and that their needs were *picked out*. The female service users felt that their background and development was taken into account. The referrers felt that the process was in-depth and not event focussed. Prison referrers said that it made the information accessible whilst the community referrers said that the process was supportive and included good communication. The assessing staff felt that the positive aspects included the structure of the interview being a well-rounded approach that saw the person being assessed as a whole person and looking at how they fitted into the world with open ended questions allowing a flexible approach. The miracle question, (Iveson 2002), (appendix 10.1), was seen as helpful by both services.

The second theme concerns the location and length of the assessment interview. Service users said that somewhere quiet with ease of access would be preferable. Prison based service users would prefer to be seen on their own wing if possible. Referrers were concerned with staff safety but felt that service users should be consulted. They also felt that wings should be used in the prisons if possible.

Assessors felt that there should be choice for service users. Assessors also felt that the interview could be split into several sessions if needed.

These main themes discussed in this chapter, along with group and sub-group themes are presented in Table 7 below:

THEME	GROUP	SUB-GROUP	DETAILS			
HOLISTIC	**SERVICE USERS**	**Male**	comprehensive	safe	Needs picked out	
		Female	background	development		
	REFERRERS	**Prison**	In-depth	Not event focussed	Accessible information	
		Community	In-depth	Not event driven	Supportive	Good communication
	ASSESSORS	**Psychiatrist**	Adequate	Constructive	useful	
		Nurse	Person as a whole	In own words		
		Psychologist	Rounded	Structure	Fitting in the world	Self-image
		Social Worker	Whole person	Structured	Open ended framework	
LOCATION/ TIME	**SERVICE USERS**		Ease of access	Quiet	On wing	Time taken to explain
	REFERRERS		Staff safety	Discuss with SU	On wing	
	ASSESSORS		Choice	Discuss with SU		

Table 7: Research Question 2 themes

From my perspective as an auto-ethnographic researcher in this service, I feel that the FAF does make the assessment process more holistic. The framework it offers allows the service user an opportunity not usually found in forensic assessment to contribute as an equal partner. The service user is given the opportunity to discuss their opinion of how they fit into the world (discursive elements) and how being in the world impacts on them (intrapsychic elements); a perspective not usually encountered in forensic assessments which will normally focus on the historical and

presenting issues, (material elements). Using a format like the FAF can also avoid the assessment being dependant totally on the skills of the assessor to tease out the detail necessary to achieve a holistic approach.

6.2.1 Holistic

Holistic is defined from a medical perspective as '*the treating of the whole person including mental and social factors rather than just the symptoms of a disease',* (Oxford University Press 1991 p562). The NHSIQ document on holistic common assessment states that:

> '*The holistic common assessment process offers an opportunity to explore the individual's wider needs and identify what action should be taken to meet them. There should be a strong focus throughout on supporting choice and decision-making and on helping people identify and achieve the outcomes they want for themselves wherever possible'*
>
> *(Richardson 2010 pp6-7)*.

The main focus of the FAF is to encourage a move away from symptom or risk focussed assessments towards multidisciplinary assessments that look at all the parts of an individual and how these elements are interconnected and influence the service users' interactions with the world around them. This will lead to the formulation of interventions to meet the identified needs. That this is achieved by the use of the material-discursive-intrapsychic model, as adapted in the FAF, is supported by data from the 18 semi structured interviews presented in this chapter.

6.2.1.1 Service Users Perspective:

The service users stated that the FAF provided a format that looked at their background and development in detail, allowing trust and rapport to develop by showing an interest in them as individuals not merely as a set of symptoms or risks. At times, the assessment was seen as deep and difficult by the service users being assessed, but they felt that the outcomes were positive due to this holistic approach.

The pre-study focus group felt that the FAF allows a more comprehensive assessment that does not focus on the 'event', but allows the development of the circumstances around the 'event' to be more thoroughly assessed. They liked this ability of the FAF to allow a more comprehensive assessment and suggested that this element should be discussed in the interviews.

Service user 1, a prison based service user, felt that the assessment format looked at her background and that was important in getting to know her. Not being judgemental in an assessment can build trust to discuss difficult issues and helped her to feel comfortable.

Interviewer Do you feel your background and development was taken into account?

SU 1 *Obviously, if you know my background…I don't know…if you know my background and…you'll know me better as a person and what I've been through and what I've gone through. And that, maybe I guess that's why I am like what I'm like today.*

Making an effort to tease out the trajectory of service user 1's life, the choices she made and the influences acting on her in order to understand how she developed into the person being assessed is important to her. It is also vital in gaining an assessment that is holistic and can inform outcomes and understanding of risk development and schemas.

Service user 2, a prison based service user, has experienced being assessed previously without people getting to know his background, having preconceived ideas about his needs and not giving him the time to discuss issues he feels are important. He felt that the FAF was comprehensive and did not pigeonhole him. He went on to say that he felt safe during the assessment, and could finally talk about *certain things.*

Interviewer So, how would you describe your experience of the assessment process, with that system and the assessment we did?

SU 2 *The assessment done here was far more comprehensive and you had, and still have, time to talk about something even if you're not sure where it's going. You're not on a timescale where, look, we'll have to move on; you've got other people to see. If you come back again, we'll talk about it another time; you know you'll get it off your chest. Whereas, there you are just pigeon-holed, basically, so it's a lot better... now I can talk about, feel safe to talk about certain things. I have been able to talk about things from the past with you. I remember talking about what happens on a day to*

day basis as well, which is just as important. But I could only afford to do that during this assessment

Having an interview schedule that is based in critical theory to ensure a holistic approach avoids service user 2's previous experience of being pigeonholed which resulted from assumptions being made prior to the assessment being completed. Creating a safe environment to share information that is difficult to discuss is encouraged by the FAF having a running order that leads towards more difficult subjects gradually.

Service user 5, a community based service user, required a long period of rehabilitation in a non-forensic inpatient unit and was assessed as part of that process. Although giving short answers and struggling to engage, he attended the interview sessions and this research interview willingly. He understood that the process would be long and comprehensive, and that it did discover that his perceived risks were less than previously assessed by the local team.

Interviewer Was it your experience that you were assessed as an individual taking into account everything rather than just looking the events, the things that had happened?

SU 5 *Yes, yeah, it was yeah, it was in depth.*

The ability of the FAF to engage with and assess challenging service users is reflected with this service user whose assessment resulted in his rehabilitation plan being accelerated and his successful discharge being facilitated. The FAF used a holistic approach and developed an understanding of his past schemas associated with his perceived risks which led to a reduction in his risk status.

6.2.1.2 Summary, Service Users Perspective:

The male service users stated that the FAF was comprehensive, safe and that they had their needs picked out. The interview schedule provided by the FAF, informed by critical realist theories, ensures a holistic approach which avoids acting on assumptions. They also appreciated the safe environment created by the running order of the FAF gradually building towards more difficult areas. The flexibility inherent in the FAF approach helped to aid completion of assessments that looked at all elements of the individual. Engaging with more challenging service users is

helped by the holistic approach that does not focus solely on events or perceived risks. The female service users appreciated their background and development being explored to tease out the trajectory of their life story and gain an understanding how they arrived at the point of assessment and also to help them with future planning. The differences between male and female service users can be explained by the willingness of female service users to talk about their experiences and the initial reluctance of male service users to feel comfortable and safe enough to discuss these areas.

6.2.1.3 Referrers Perspective:

The referrers stated that the FAF gave a thorough and detailed assessment that it allowed a clear formulation to take place. They saw this as a result of the holistic approach that looked in detail at the background and development of the service user. They felt that this was an empowering experience for the service user and that the amount of time given to the assessment was important as it allowed themes to be explored. There were several discussions about involving the referrer in the assessment process, which they felt could be positive and helpful. Some felt that the FAF considers the thoughts, feelings and experience of the service user and the care co-ordinator together which leads to a more holistic assessment.

Referrer 1, a prison based nurse manager, sees the FAF as offering a more in-depth assessment that gives a better picture of the service user. She feels that the assessment is holistic, and not event focussed and that she would like to use that approach in her clinical practice.

Interviewer How would you describe your experience of the assessment process with the forensic community team and with other assessments that you have done with other specialists?

Referrer 1 *Well certainly from even just an initial assessment to the forensic assessment tool they give a lot more information than just skimming the surface with the initial one. With the forensic one you actually looking more in-depth and you are not just looking at present you are going in to the past and you just get a lot more information from the client which gives you a better picture then of the client's life rather than just the here and now.*

The referrer accepts that the FAF will explore the whole person, not just focus on the event. This is achieved by the model used and the comprehensive nature of the schedule. The referrer would like to emulate this approach, but understands that FAF ensures that this is the approach used by the Forensic Team.

Referrer 2, a prison based nurse manager, felt that the FAF was more in-depth, informative and had a formulated outcome that was superior to others, in his experience. He stated that the FAF looked at all aspects of the individual and that the service user was given time for a full assessment. He said that his previous experience of forensic assessment was looking simply at risk and the here and now.

Interviewer ...you felt the background and developments were taken into account?

Referrer 2 *Absolutely, yea...Looking at one of the ladies I referred, there was a lot of information in there that I didn't even know, and I'd nursed her for over four years. I think that's what we're poor at in prison, as I say we deal with the here and now; we deal with her admissions but we don't actually get the wealth of information in the community itself, because we haven't got the time to reach out to get GP notes to interpret them unless they are an extremely complex case.*

The level of in-depth information reported back to the referrer following assessment using the FAF is appreciated. That it looks to gather information on the generative forces influencing the service users' history rather than focusing on the here and now is seen as a benefit. Referrer 2 also has a relationship with the FAF and its subsequent report following assessment that supports previous arguments that the FAF is a Boundary Object as defined by Leigh Star, (Star 1989 p37).

Referrer 3, a community based consultant psychiatrist, felt that the FAF gave a realistic, comprehensive and thorough assessment. In his opinion this may be because the FAF allows a fresh perspective to be taken without the prejudices and assumptions of the referring team.

Interviewer Looking at the holistic nature of assessments as we try to do them, did you find that the service user you referred was assessed as an individual taking into account all their experiences, not just focusing on events?

Referrer 3 *Erm, yes, I think very much so...Very often the agenda nowadays from general adult services is about events, that referrals are often 'events driven'.*

Again, the element of referrals and assessments being event driven in general psychiatry and that events are the focus rather than the service user's background and development is counterintuitive. One would expect that event focussed referrals

would be more common in forensic psychiatry following, for example, serious offending behaviour as the risk associated with forensic service users could result in more serious consequences. It may be that in general adult psychiatry, crisis management is more of a focus, due to caseload pressures, than understanding the generative forces and schemas behind an 'event'.

Referrer 4, a community based Community Psychiatric Nurse, stated that she tends to take several months to complete each of her assessments and includes a relapse signature element. She stated that the FAF assessment considers the thoughts and feelings of the service user, will draw in the care co-ordinator, which she strongly supported, and is a very holistic way of working. She saw the FAF as structured and specialised and that it can elicit more in-depth information from service users.

Interviewer How would you describe your experience of the assessment process with the Forensic Team…?

Referrer 4 *Absolutely great, the communication with the forensic team is wonderful, erm, you know, and they are extremely supportive through the assessment period, they can consider the thoughts and feelings of the client and try to make things a lot easier for them, and try to draw in the care co-ordinator if there are any issues that, ...er, and it's a very holistic way of working, in my opinion...because of the structured approach they were using, er, we actually learnt something about the young man that we didn't know, and we've been with him now for over five years...And it's much easier for the forensic team to do that I suppose. But I think that what was interesting about the document that you use is that it has, it appears to have pathways where you can elicit more in-depth information from somebody.*

Referrer 4 highlighted the holistic element of the assessment process as she saw it, treating the service user with consideration, involving the care coordinator for support during the process. She identified that the structured approach of the FAF allows in-depth information to be gathered using what she said were *pathways* that reflect the macro/ micro focus that can develop with the FAF as discussed in the previous chapter, (5.2.1.6).

Referrer 5, a community based nurse experienced in substance misuse services, felt that the service user was empowered by the FAF assessment process and that it was a very positive experience, particularly when it was a joint assessment promoting partnership working. The level of detail allowed the triggers for certain behaviours to be understood and helped to put the more forensic elements into perspective, such as segregation in prison being a process rather than resulting from

aggressive behaviour per se. She saw the FAF assessment as detailed, individualised, client centred and respectful. She was happy with the assessment process feeling it was very detailed and did not miss any information.

Interviewer Did you find that the service user you referred was assessed as an individual taking into account all their experiences, not just focusing on events?

Referrer 5 *Very much so, it was very detailed around his childhood experiences and his family background which helped myself see some of the triggers for his behaviour traits. And the assessment wasn't being clouded by, often what can happen, it can be clouded by agencies saying it's the clients substance misuse behaviours, but that wasn't the case whatsoever and it was very clear around, er, his previous experiences in prison and how he felt; previous contact with services, which was quite minimal and detailed family information...where he grew up, his experiences of school, his experience in a care home. And the client appeared very open and honest in relation to some very sensitive issues.*

The reason that referrer 5 felt that the FAF did assess the service user she referred in a lot of detail was that it did take into account all of his background and development to understand his triggers, and did not focus purely on his substance misuse issues. That he could feel safe enough to discuss *sensitive issues* reflects on the way the FAF is designed to build trust as the assessment progresses.

Referrer 6, a community based social worker, found the FAF quite thorough and did not see any aspects missed out. He saw the FAF as taking all the background and development into account to put events into context. One service user he referred had a specific assessment provided within the FAF, an assessment of stalking behaviours and attachment pathology.

Interviewer Do you feel that their background and development was taken into account to put events in context, with the community team and with others?

Referrer 6 *Yeah, I would say definitely so because we did look at the family history, relationships with the service user's siblings, events during school; events which may have precipitated why he may have gone to that type of offending behaviour.*

Referrer 6 highlights again the level of detail that the FAF goes into to gain its holistic assessment of the service user he referred. As the assessment identified issues around attachment, it led to a further assessment of stalking behaviours. This is one of the branches possible after the initial assessment; others include formal assessment of personality disorder, psychopathy, fire-setting, substance misuse, trauma, sexual offending and IQ testing, all performed using validated assessment guidelines.

6.2.1.4 Summary, Referrers Perspective:

The referrers interviewed in this study stated that they felt that the FAF is an in-depth method of assessment that is not focused on events but looks at service users as individuals in a holistic manner. The prison based referrers were more focussed on receiving accessible information than the community based referrers who wanted to be involved, supported and kept up to date with the assessment.

The prison based referrers stated that the in-depth element did not focus on the here and now because of the schedule it provides in an assessment interview. It provided information on the generative forces from the service users' background by completing a comprehensive and holistic historical assessment. This comprehensive history given in the subsequent report was appreciated by these referrers, as they stated that they usually did not have the time to gather all the information together.

The community based referrers felt that a forensic assessment was an opportunity to take a step back and look holistically at the service user, including their background and development, not just focusing on events. That the assessment treated the service user with consideration and involved the care team and carers in the assessment enhanced its holistic intent. The structured approach and pathways in the various sections of the FAF do lead to more in-depth assessments. They also felt that understanding triggers to risk behaviours was enhanced by the comprehensive and holistic nature of the assessment process.

The prison based referrers felt that having an accessible report containing an in-depth history that was not event focussed was beneficial as the prison-based service users may spend periods of time away from their current institution, either in the community or at other prisons, and that report can be a beneficial synopsis for people new to the individual. They felt that this could avoid difficulties arising in the future with information being missed or overlooked. The community based referrers also appreciated the in-depth and non-event focussed nature of the assessment, but they also wanted on-going support and communication with the assessors in managing the risk to others that they perceived the service user as presenting.

Referrers also felt that the FAF process was a safe place for service users to discuss sensitive issues. The structured approach also led to further assessments of specific areas identified, such as firesetting, stalking or sex offending.

6.2.1.5 Assessors Perspective:

The assessing professionals from the Forensic CMHT stated that the FAF is a useful assessment guideline that was not restrictive and provided an excellent framework for assessment. It was also described as adequate and working reasonably well; that it was quite constructive and useful and, at times, goes into quite a lot of detail. It helps to find out how the service user feels they fit into the world and is a solid foundation for assessment. The way the FAF is organised helps to build trust and rapport with the service user. It focused on some issues not normally assessed, which was felt to be constructive. Some of the questions in the FAF were found to be difficult to explain to the service user and it was felt by one nurse that some professionals' life experiences did not equip them to understand service users' experiences. Service users should be part of the assessment process not recipients of an assessment and the FAF helps with that collaborative enterprise. Involving the referring service in the assessment was seen as a positive practice. One of the benefits of the FAF is that two assessors from different professional backgrounds usually do each assessment which provides a safety net in ensuring that the service user's needs are met. The psychiatrist felt that doing collaborative assessments with other professionals was challenging and could be 'messy' but had its benefits in making the assessment comprehensive and helped to avoid missing areas out. A general theme of needing to understand the service users' background and development continued; it was felt that the FAF did a good job of guiding the assessment of this area.

Assessor 1, a psychologist, felt that the FAF was a useful standard assessment format that gives the process some structure in finding out how the service user feels they fit into the world. He feels that the material-discursive-intrapsychic model, (Ussher 2000a), allows an extra bit of depth and understanding of the service user.

He sees the FAF as a solid foundation for assessment but would like it to be more collaborative. He does see it as more rounded than other methods he has used, but not when considering service users as individuals. He finds that looking at background and development in more detail benefits the assessment and saw the miracle question as helpful. He emphasised that assessment should involve service users as being part of the process, not recipients of an assessment.

Interviewer How would you describe your experience of the assessment process...with the forensic community mental health team using the Forensic Assessment Format?

Assessor 1 *Erm…positive I think... it's helpful in the FCMHT itself to have that standardisation across the board, across the disciplines. Erm, so quite positively as well, but also what I find useful from it is the fact that it does look at those other things, the material, the discursive and so it looks at it at a slightly different depth, a slightly different level of complexity then...but I have started to incorporate that into, like, my assessments outside the FCMHT...I think our model is different to that because the way that the assessment itself is structured and the way that the issues and the areas that we cover, gives it a much more rounded, er by default you know, erm, look at that person that the referring team doesn't see or doesn't acknowledge in a way that we perhaps need to.*

Assessor 1 understands that the FAF gives a consistent multi-disciplinary assessment that looks at the service user in a holistic way. He appreciates the extra elements he now has in his armoury and has utilized elements of the assessment format in his other work outside of the forensic CMHT. He draws on several specific elements of the FAF to support this conjecture, including the material and discursive sections as well as asking about self-image, stress management and how they fit into the world. He also feels that the innate holistic structure of the FAF can challenge attitudes of referring teams who see a risk and who want the forensic CMHT to '*take it away*'. Assessor 1 would like the assessment process to be more holistic, and as stated in the previous chapter, more collaborative, but accepts that it is a move towards that goal.

Assessor 2, a senior social worker, stated that the way the FAF is organised allows the professional to build trust and rapport by finding out about the service user as a person before looking at the offence or risk related issues. He felt that the structure of the FAF ensures that the assessor goes through these steps. He also felt that the FAF was not restrictive, provides an excellent framework with less likelihood of missing details and it presents as professionally developed.

Interviewer Looking at a holistic approach, did you find that the service users you have assessed are seen as individuals, taking into account all their experiences, not just focusing on events?

Assessor 2 *Very much so, I think the fact that we do so much around the non-risk issues, that we actually look at peoples history, where they've been, what they've done, schooling, education; that we're looking at the whole person not just the events that cause concern. They might be wrapped up in some of their concerns, but I do find that the way the interview structure is, you don't get to the meaty, I suppose meaty issues is the wrong word, but I suppose the issues that cause the main concerns, why they have been referred, they come in later on. So, you get a chance to warm people up, talk about them and actually show genuine interest in somebody's past history, and that tends to open people up, even if they are not expecting them to begin with…you do try to put people at ease by starting on who the person is, what they are about, forget the mental illness, who they are first and foremost. But again, it's having that structure that ensures you go through those steps...It's not restrictive, that's one of the pleasures about it; it's open ended...it provides an excellent framework to base your knowledge and experience around, and you don't miss anything or you miss much less.*

Assessor 2 focuses on the structure of the FAF that ensure a holistic assessment covering all the elements that contribute to the service user as an individual, with the ability to be open ended and follow areas of interest that teases out those generative elements from their past.

Assessor 3, a consultant forensic psychiatrist with 15 years' experience of assessment, started by stating that doctors have a way of doing assessments on their own and that they can find it difficult to adjust to collaborative assessments with other professionals. He did feel that there were some benefits to collaborative assessment, such as picking up on each other's omissions, but also noted that it could get a little messy at times if the other assessor interrupted inappropriately and broke a train of thought. He felt that the FAF was adequate and worked reasonably well, including background and development. He said that it focused on things that he did not usually ask about which could be quite constructive. He noted that the FAF gives cues on what to ask about, but that the assessor needs to develop these and probe where necessary. He also noted that the discursive and intrapsychic elements were at the end of the FAF and people could be getting tired by that time. He felt that it should include questions on finances. Overall, he felt that the FAF is a reasonable tool that can be quite constructive and useful at times.

Interviewer What about your experience of the Forensic Team using the Forensic Assessment Format?

Assessor 3 *It works reasonably well. From my own personal perspective, it doesn't quite fit the way I like to structure my assessments, but it's adequate, and it includes things I tend not to focus on, for example, religious beliefs, stuff like that. But it's actually quite constructive sometimes, and you learn things about the person and the way they think, which is quite useful to you...unless you understand where they come from it's very difficult to make sense of what's going on right now.*

Adjusting to an assessment process that involves working with different professions has proved most difficult for the medical members of the service in this study. However, this psychiatrist does see some of the positive elements that have been of benefit to the service by using the FAF. It can counter the difficulties encountered when a referring team has a different agenda for the assessment as it is a defined schedule that applies to all service users assessed, regardless of specific risks.

Assessor 4, a senior nurse, felt that the service user has to be an equal partner in the assessment process and that you cannot fully understand them as a person without exploring their background and development, which she felt is not always seen as relevant to some teams. She felt that the FAF goes into a lot of detail although some areas may overlap. Seeing people as individuals was important to her, and sometimes she felt that it is difficult for professionals to understand some of the life experiences of the service users they assess. The importance of being holistic in assessment was stressed in that you need to know the background and development not just the recent events in order to understand them as a person.

Interviewer As another element of that, do you feel that that their background and development was taken into account to put events in context?

Assessor 4 *Yeah, or yes certainly. You can't…you can't kind of understand where they were at today unless you look at the person, as a whole, where they are at today, even if you establish that there has been a sequence of events that's led to the end result or there is one big ginormous...just become really unwell or become the victim of something… so yeah.*

The ability of the FAF to look past *events* in an effort to find out where the service user is *today* is achieved by the holistic nature of the model used. Sometimes, a serious offence can overshadow an assessment and limit the search for developmental, historical or schematic clues to an individual's presentation, risks and needs.

6.2.1.6 Summary Assessors Perspective:

The assessors stated that they felt that the FAF is a useful, structured, rounded assessment format that assesses the whole person and how they fit into the world. This equates to a holistic approach to initial forensic assessment that has been socially constructed. As a boundary object, the FAF is useful in gathering information from other social worlds associated with the service user. Gaining information from the criminal justice system, including police, probation and the prisons, as well as relatives and carers' and community support services such as housing and education can inform the assessment to make it more holistic. This information pathway can be reversed on completion to include these different social worlds in meeting the identified needs of the service user, (Kimble, Grenier et al. 2010).

The different professionals interviewed had perspectives that reflected their backgrounds. The psychologist appreciated the consistent MDT approach that challenges risk assumptions due to its holistic nature. He appreciated that the elements that assessed self-image and stress management in the discursive and intrapsychic sections, reflecting a psychological understanding of the service user. The social worker felt that the structure of the FAF ensured a holistic approach with open ended questions that teased out generative forces from the service users past, reflecting an interest in the social circumstances and history of the service user. The psychiatrist did find it difficult adapting to joint assessments with other professionals when his profession usually complete assessments on their own or with medical colleagues using their medical model. He did feel that the defined schedule ensured a consistent approach and added new elements to the assessment process. The nurse stated that the FAF looked to past events to offer explanations about current behaviour due to its holistic nature, without being limited to serious offences, which reflects a nursing focus on planning care to address current presentation.

The interviews in this section support the proposition that the FAF is an assessment guideline that has contributed to improving the initial assessment process in this service by encouraging the separate focus of each professional assessor's perspective to be brought together in a holistic manner.

6.2.1.7 Comparator Group Perspective:

The two assessors from the comparator group had similar thoughts about the need to see the service user as an individual and to take background and development into account. One felt that the assessment dataset they used (*HCR20/ PCL/ IPDE* chapter 2.3.6) was prescriptive and designed to look at risk and provide the Ministry of Justice with facts and figures rather than be a person centred collaborative model. The other felt that his experience of assessment in other teams had been quite basic, focusing on the here and now. He did highlight the *Tidal Model* (Barker 2000), as the 'most illuminating'. He emphasised that the quality of the assessment depends on the quality of the relationship between assessor and service user. The skill of the assessor can help the service user to have a greater contribution to the assessment outcome.

Service User 6, a community based service user, felt that the assessment he had was more detailed than previous ones and that he feels better about himself, although he still has suicidal and homicidal thoughts. As he felt supported through the assessment process, he said that it was easier to talk to them about issues he had not previously discussed.

Interviewer	Do you feel when they first met you that they looked at your background and development and those sorts of areas, to try and put all the events into context, try and understand you better?
SU 6	*Yeah well, I told them a lot, so, I telt them things I have not telt* (told) *anyone else, so…and there's still a lot I want to tell them, most of it sick and…I feel a lot better about meself, I still want to top (*kill*) meself and that, and top other people. However, I feel a lot better.*

For the comparator group, assessment can take many months involving dozens of sessions with each service user. The level of trust that builds over this time has helped service user 6 to be open and honest with them, even if his risks remain evident.

Assessor 5, a senior occupational therapist in the comparator service, felt that the assessment dataset that they use is quite prescriptive and designed to assess risk and generate data for the Ministry of Justice, who provided their funding. She felt

that it could be seen as a long and drawn out process, on average 16 sessions, but that it was not seen in that light by the service users who felt that it was just about talking about what happened that week. She felt that seeing a service user as an individual, not just focusing on events, was important to gaining a full assessment. Gaining an in-depth look at the service user helped to meet their needs. She reports that services appreciate the amount of detail in their reports.

Interviewer Did you find that the service users you have assessed are seen as individuals, taking into account all their experiences, not just focusing on events?

Assessor 5 *Yes, yes I think so. I think the major thing, especially in a personality disorder service, is don't look at events, you kind of look at what has contributed to that, you look at history, environment, schema, and beliefs and you almost look at events being a product of the rest of it rather than just responding to that.*

Using a set of validated assessment guidelines such as the *IPDE*, *PCL* and *HCR20* to assess service users' personality, level of psychopathy and risk of violence to others will achieve that objective. What the assessment may miss is other generative elements that have been shown to be important in the assessment of forensic service users. Having a focus on providing a risk management plan to referrers and data to the Ministry of Justice may detract from a comprehensive assessment of the needs of the service user.

Assessor 6, a relatively new forensic CPN in the comparator service but with 12 years experience as a mental health nurse, discussed his experience of various assessment models including the *Tidal Model*, (Barker 2000), which he sees as a client led model, and care co-ordination which he reports as *kind of basic*. His experience is that the quality of the assessment is dependent on the quality of the relationship between service user and assessor. He felt that important issues to assessment were the skill of the assessor and the contribution of the service user. He felt that the current assessment model in his service did take into account the background of the service user and uses lots of different sources. He added that the Miracle Question (see FAF appendix 10.1) helps to ensure that the service user's perception of their needs are included.

Interviewer Did you find that service users you have assessed are seen as individuals, taking into account all their experiences, and not just focusing on events?

Assessor 6 *Erm, again, dependant on the model that was carrying out...It's where I suppose...no, that doesn't necessarily mean a medically model-led, er, assessment won't necessarily look like that, but it seems to me that there is more chance of it being*

> *meaningful if the patient feels that they have contributed sufficiently to it. Erm…otherwise, you know, it tends to look, erm, very 'text book', very 'clinical' ultimately, but, you know, in a very impersonal way*

Assessor 6 would like his assessments to be *meaningful* and have the *patient contribute sufficiently* avoiding it seeming *clinical*. He feels that this is achieved through the quality of the relationship he has with each service user rather than being encouraged by the assessment guideline he uses.

6.2.1.8 Comparator Group Summary:

The comparator group use different assessment guidelines that can seem more focussed on meeting the needs of the Ministry of Justice or the referring service than the service user. However, their objective remains gaining an assessment that is individualised and holistic.

The service user felt that the team built trust with him over dozens of sessions over a 12 month period and that he felt happier, but also agreed that his risks to himself and others remain. The occupational therapist felt that the assessment process used is prescriptive due to having to use the national dataset. She did see the service user as an individual and completed a comprehensive history. The nurse said that it is important to encourage the service user to contribute to the assessment, but feels that this is dependent on the relationship between the assessor and the service user not the process used.

The comparator group seeks to attain a holistic approach to assessment, which seems focussed on the skill of the assessor to ensure it is achieved rather than by using a process, such as the FAF, which, as a collaborative, holistic and inclusive model that acts as a boundary object to ensure a comprehensive approach to assessment.

6.2.1.9 Jon's perspective: Holistic

In an effort to move away from risk or symptom focussed assessment, I aimed to develop an assessment process that could be seen to be holistic, identifying the needs of service users and planning to meet them. The people referred to the forensic CMHT cover a diverse population and their trajectories can vary. Living in the community, prisons and hospitals and having individual stories, experiences and social contacts they require a flexible approach to assessment that can access all these facets. A common story from female offenders in the prison system referred for assessment includes a history of trauma usually emanating from male influences in their life. This could be a relative or a partner but usually includes a controlling relationship along with physical, emotional and sexual abuse.

One such lady referred for assessment, Service User 1 in this study, told me that she appreciated the opportunity to discuss her background and development as well as her history of abusive relationships. Her trajectory into adulthood had led to her developing a drug abuse problem that she battled with over many years. In the prison environment, with support and routine, she did move away from illicit substances and disruptive behaviour. I first met her in the segregation unit following an assault on another inmate and we developed an understanding that she would talk with me if I did not tell her 'how to run my life'. Over several sessions we completed the assessment and she took the opportunity to express emotions that she had not previously acknowledged. She declined further follow up for her identified trauma and mood issues, and was located back on her wing to complete her sentence. However, several months after release, she returned to illicit drug use in a moment of high stress and unfortunately, as noted by the coroner, succumbed to an accidental overdose of opiates as she was not used to the purity of street drugs in the community, which has been noted as not unusual in a meta-analysis by Merrall, Kariminia et al, (2010). I felt that service user 1 should have received more support on release, but she was seen as an offender with drug problems not as someone who needed or wanted community mental health support. As is common in the female prison estate, she was not from the area near to the prison and her release was preceded by an unexpected transfer to a prison more local to her area, which impaired communication when released.

The short length of sentences issued for drug related offending does not allow a complete assessment of needs and the planning necessary to meet them. Understanding the trauma usually related to long term drug use and its impact on mental health requires a holistic approach. Empowering women in this situation requires a change of approach in how they are perceived.

In a community based assessment, a service user was seen as a high risk to women in the community and was being supervised by the probation service and MAPPA at level 3, very high risk. A FAF assessment looked at him as an individual who had developed from all the experiences he had in his life. This highlighted that personality disorder was likely to be an issue and IPDE and PCL-r assessments were indicated. These assessments confirmed that his history of offending against women was part of his personality profile and likely to reoccur. As he was unwilling to engage in any interventions, the MAPPA panel petitioned the Ministry of Justice for a trial of a GPS tag to manage his risks. This resulted in the prevention of further assaults and his return to prison when he was observed to have entered an area from which he was excluded. This example may not seem to be service user centred, but the result of his return to prison was that he did not commit more serious offences that would have resulted in a longer period of imprisonment and a further victim. The boundary object principle was evident in this case, as communication between the forensic CMHT and secondary mental health services was expanded to include probation, police (including the Public Protection Unit), Housing and local council street monitoring services.

At the outset of this project I noted that service users are seeking insight, referrers want to know about risks and assessors want to complete their report. Towards the end, it would seem that service users want to be treated as an individual; referrers think about getting a good history that is thorough and assessors find that the FAF is a good format to use in achieving these objectives.

One of the elements that the FAF helps with is in report writing. By providing a report template with all the sections headings in place, the assessors have a framework in which to develop their assessment, ensuring a more complete and holistic process.

6.2.2 Location & Length of Interview

The location of the assessment was seen as important by service users, who felt that ease of access and a quiet environment were important. The referrers felt that staff

safety needed to be considered but that service users should have an element of choice. Assessors felt that local choices should be discussed with service users.

The length of the assessment process using the FAF was seen as acceptable and responsive to service user's needs by the three groups involved.

Caroline Logan offers practical advice on the location of clinical interviews and states that the minimum requirements are that the room should be neutral, i.e. not distracting; warm, private and quiet. Barriers between the assessor and service user, such as tables, should be avoided and that the chairs should be laid out at an angle with the assessor nearer the door for reasons of safety, (Logan and Johnstone 2013 p266).

6.2.2.1 Service User Perspective:

Service users felt that being given sufficient time to discuss certain issues was important to them and they felt that the FAF gave them that element of time, even if the assessment had to be completed over several sessions and was perceived as long and inquisitional by one service user. Most of the service users felt that the location of the assessment was important, especially the prison based ones. Ease of access and a relaxed quiet environment were seen as important. Having sufficient time and a relaxed location contributed to gaining a holistic viewpoint.

Service user 1, a prison based service user, felt that having the assessment over several sessions gave her an opportunity to think about what had been discussed and to consider questions she wanted to ask. She did not find that the location of the interview was important.

Interviewer Did that help, having it in different sessions, as opposed to having it all in one go?
SU 1 *Because it gave me time to think of questions I wanted to ask you*

The format of the FAF allows breaks to be taken at the end of sections and picked up at the next session.

Service user 5, a community based service user, found the assessment a little long and inquisitional, but said that it was pretty good. He would have liked more information before and after the assessment and he liked the idea of choosing the location of the assessment.

Interviewer What is your opinion on the length of the assessment interview?
SU 5 *It was a bit long, yeah...it seemed to be too formal. There is a pressure element to it; you know...It seemed really, it seemed a bit inquisitional.*

These responses show the importance of creating the right environment to complete an assessment. This assessment could only take place in a meeting room around a large table rather than a smaller more relaxed environment. The service user had little information prior to the assessment from the referring team and his experience informed the way information is passed to service users prior to interview.

6.2.2.2 Referrers Perspective:

The length of the assessment, at about 2 hours on average, was seen as acceptable. There was some divergence about the location of the assessment with some referrers being more flexible to service user needs than others who felt that staff safety should be the highest priority. The need for some initial feedback after the assessment was felt necessary as reports can take some weeks to arrive.

Referrers 1 and 2, both based in the prison system, felt that assessing service users on the wing where they may feel more relaxed is preferable to bringing them to the Healthcare Centre, but that risk must be considered when making a decision. Referrer 2 also said that the assessment should take as long as necessary as it is a specialist assessment, which will be more complex.

Interviewer Do you feel that the service user should have a choice were the assessment takes place?
Referrer 2 *...In healthcare yeah. I definitely think that's something we are looking at; we have to risk assess the environment but…working a community model, the community is their wings; the cell is their home so why can't we enter that area as long as the risk assessment says we can do.*

This agreement with the prison based service users perspective indicates that creating the right environment for an assessment can influence the level of holistic and collaborative elements that result.

Referrers 3, 4 and 5, based in the community, agreed that the service user should have a say in where the assessment takes place, if possible, as they would feel more relaxed and comfortable helping them to engage more in the assessment process.

Interviewer Looking at general issues now, what is your opinion on the length of the assessment interview?

Referrer 5 *Erm, the assessment was conducted over a couple of sessions which appeared an appropriate time period for that information. The client very much wanted to share all his information around his childhood and background. So it appeared to be an adequate timescale for that so that the client could, over a couple of sessions, engage with your service...we have some of the most serious, high risk offenders, so no, it needs to be in a safe and secure environment that we have access to alarms. It's about risks to staff.*

Referrer 6, based in the community, said that he did feel that it was quite a long assessment and that there was a lot of pre-planning and discussions with the rest of the MDT and his family prior to the service user being seen. He said that the service user did not express any discomfort with the location of the assessment which the referrer felt was fine.

Empowering the service user to have an influence on where the assessment takes place helps to build an element of partnership that can promote a holistic approach to assessment. The referrers wish for safe environments to be used is understandable. In reality, a choice of location is usually a local mental health resource centre or a GP clinic as opposed to having to travel to the forensic CMHT office that can be up to 50 miles from some parts of the area covered by the Trust that the team is based in, (Fig 8 chapter 4.4).

6.2.2.3 Assessors Perspective:

All the assessors felt that the assessment was lengthy, but that this was justified as

to be holistic; it needed to consider all elements of the service user being assessed. They also agreed that the service user's wishes on assessment location should be considered, with caveats due to staff safety.

Assessor 1, a psychologist, accepts that forensic assessment can be a lengthy process and that service users should be accommodated as far as possible on the location of the assessment.

Interviewer Do you feel the service user should have a choice of where the assessment takes place?

Assessor 1 *Absolutely, yea, I think the way I see it at the end of the day is that, erm, they have been referred to our team, they don't have to co-operate with that, it's not incumbent on them to be there anyway, according to statutory regulations or whatever.*

Assessor 2, a social worker, stated that the length of the assessment could be long, dependant on the assessors, but it has to be thorough and 'cover all the bases'. He supports the service user having a say in where the assessment takes place, but risks have to be kept in mind.

Interviewer Do you feel the service user should have a choice of where the assessment takes place?

Assessor 2 *I think, within reason, yeah. There might be certain cases where the level of risk presented by them dictates where the assessment takes place.*

Assessor 3, a psychiatrist, felt that more than one session is usually necessary as the assessment will take as long as it takes. Safety for staff is a driver for the location of the assessment, but options within that parameter could be put to the service user.

Interviewer What is your opinion on the length of the assessment interview?

Assessor 3 *It's a real struggle to get it done in one session. And that's going to be the way for any sort of format we have, which is one of the reasons why I try to say to people we can come back again, you know, sure, we're getting bogged down here, but let's just ride with it, we'll come back another day.*

Assessor 4, a nurse, felt that the assessment needs to be as long as necessary, but that prior information gathering can help reduce this. Giving the service user a say in the choice of assessment location was seen as important to help them feel comfortable.

Interviewer Do you feel the service user should have a choice of where the assessment takes place?

Assessor 4 *...Yeah, I think we do, you've got to make people feel comfortable in order to get the best from them, and sometimes…there's got to be an element of discussion and negotiation, but obviously taking into consideration risks and availability.*

For the forensic CMHT in this study, location of assessment is an issue due to the geographical size of the area that they cover. Simply inviting service users to come to their base is unrealistic as travelling times on public transport could be prohibitive. A process of locating suitable facilities around the Trust or using GP surgeries/ Healthcare facilities has developed. Assessments in the service users' home do not take place for safety reasons; no back up or supervision is available. However, within those limitations, service users are given choices.

6.2.2.4 Comparator Group Perspective:

The length of the assessment in the Personality Disorder Service can be many months and take up to 16 sessions. The service user's choice of location of the assessment is accommodated where possible.

Service user 6, a community based service user, prefers being seen for short sessions and found it helpful that they took place at the local clinic.

Interviewer What about the length of the assessment period, do you think it takes a long time?

SU 6 *Never last long 'cos, like, when I start talking, it's over, it's only an hour, so... I had to go to (*main hospital*) all the time, and I couldn't get up there all the time, so. I just live up in xxx, so it's easier. (*to come to the local clinic*)*

Assessor 5, an occupational therapist, tries to ensure that the assessment is completed in 2-3 months and is flexible in the location of the assessment.

Interviewer What about, you mentioned a couple of times about the length of the interview, what is your opinion on the length of the assessment process?

Assessor 5 *Erm...I fluctuate what I think about it, because, when I write out a report at the end of it, I feel as if I kind of know that person inside out, I know about their childhood, their relationships, I know about their substance misuse, I know, I know everything I can know at that point, everything that they've told me anyway. Erm...I just sometimes wonder if there is a way of getting that information in a shorter time period. But again, I do think that 12-16 contacts is not too bad. By the time you've met somebody, looked at a timeline history, then done the assessment, sometimes it's when it drags on longer than that because you sometimes think, er, by that point, other things have kind of come in and the circumstances have changed, so you could try and insure it didn't go beyond 2-3 months, that would be good.*

The perspective here is that 12-16 sessions over 2-3 months on average is acceptable for a forensic assessment focussing on personality disorder. This level of assessment can limit the number of assessments taken by this small team that provides a regional service.

Assessor 6, a nurse, tries to accommodate the service users' choice of assessment location wherever possible given presenting risks. He states that in his experience there has no set period for assessment, and that this could be completed in one session or over many sessions with supporting information from family and other services contributing.

6.2.2.5 Jon's Perspective: Location and Length of Interview

In the initial development of this model, as a CPN assessment format in the prison system, the concept of gaining a holistic perspective of service users began to include seeing service users on their wings rather than in the healthcare centre of each prison. My experience in three of the prisons generated different emotional reactions.

I was security trained and issued with keys to navigate around each of the prisons, and the first time I did this in each was interesting.

> *In a local male remand prison, the average age of inmates is in the mid-twenties. Walking onto a wing as a new face, particularly if the wing was on 'unlock' where the inmates are free to move around within the wing, was challenging. There were up to 60 inmates and as little as four staff who were generally in the wing office or not immediately visible to me. I was immediately challenged by inmates when I entered the wing being asked who I was and what I was doing on their wing. This was generally a jovial exchange as, I would soon learn, any information or gossip is currency in a system that is by its nature predictable and boring. My initial anxiety when walking through a wing dissipated over the next few weeks as a got to know that for the many, the way they presented, their bravado and confidence, was not reflected in the discussions I had with them during 1:1 assessment and intervention sessions.*

Walking onto a wing for the first time in a female prison was an altogether different experience. The inmates were a little more bold and inquisitive in attempting to gather information from me. This prison had a 'free-flow' system where inmates could move around the prison to different activities at certain times of the day. This meant that inmates could walk with you for long distances as they may be moving to the same area as you. I was expertly interrogated on many occasions by inmates looking for information, gossip and news. Learning to be professional and polite whilst declining to share information about where I was going or who I was seeing became second nature in time. On certain wings, I would get one update from the wing officer on the service user I was seeing that day and another from her pad-mate or friend as I walked around the wing. To me it was the equivalent of family and carer updates in the community.

In a high secure dispersal prison, walking around the wings could be more than anxiety promoting. The first time I went onto one of the new house-blocks where there were several dozen men serving long sentences for serious, usually violent offences, focussed my attention. To reach the wing, I had been through the security processes at the prison entrance, which included metal detectors and a pat-down search. I then drew my keys and proceeded through several gates to reach the wing, which is in a separate building several hundred yards away. Entering the wing brings you into the reception area and then you open another gate to enter the wing to access the office. The inmates were less likely to approach me at once, but I was aware that I had been noticed, assessed and categorized. The wing cleaner would generally be the first to approach or start a conversation in passing. Again, the wing-staff were usually not immediately visible, being either in the wing office or other parts of the wing. A difference in this prison was the way inmates regarded the wing as their community, where they lived, not simply a place they were passing through. I would occasionally see inmates in their cells, more usually in a wing lounge area or interview room and the level of anxiety from the service user would always be less when they were seen on their wing. As well as being in their own community, they avoided the process of coming over to the Healthcare Centre where they would be locked in a small waiting room with other inmates who may be seeing the GP, dentist or general nurse. The wait could be hours as there was only one 'movement' each way where inmates were moved from the wing to Healthcare and back.

I feel that by seeing the service users on their wing, I could gain a more holistic understanding of their environment. I also gained an understanding of the stressors and anxieties that are apparent by simply living in a prison. Understanding that there are wing officers who can provide support to inmates and information to inform the assessment is one element, but building those relationships over time can only be achieved by regular contact on the wings, not sitting in an office on the Healthcare Centre.

The theme of time has become apparent in this chapter and I have experienced the benefits of taking time to build trust, sometimes over many sessions, particularly

when assessing people in the prison system. At one point, I was able to join a difficult to engage inmate in the exercise yard several times to walk around with him talking and developing trust which resulted in a full assessment being completed. This was eventually stopped by prison staff due to ‘security issues’.

In community assessments, every effort is made to locate the assessment interviews in accessible locations such as local mental health offices or health centres rather than asking service users to come to the team’s offices that could be a long distance away due to the trusts large geographical area.

6.2.2.6 Summary, Location & Length of Interview

The location of the assessment interview is viewed the same in both prison and community locations, as near to the service users residence as possible to suit the service user and to gain some understanding of their environment. In a prison, this could be on the wing rather than in the Healthcare Centre, in the community it could be at a local Health Centre or Mental Health Unit. This could also give an opportunity for carers, family, friends, wing staff and pad mates to provide information. From the service user perspective, the location also needs to be kept informal, quiet and comfortable. Referrers in the community felt that staff safety should be the priority when considering locations. Assessing staff felt that the service user should be given local choices, but also saw staff safety as a factor.

The length of the assessment was seen as acceptable by all the groups. Service users felt that it gave time to discuss events and issues and having several sessions allowed time for them to think about questions they wished to ask. One service user did feel that it was a little long and inquisitional, but felt that it was pretty good. The referrers felt that it was as long as it needed to be at about 2 hours, but they would like some feedback more quickly. The assessors felt that the assessment interviews were as long as they needed to be to ensure a holistic assessment that looked at all the areas of the service user set out in the model used. The comparator group generally took about 16 sessions and several months to complete their assessments. They felt that gave a comprehensive assessment and provided the

referrers with a level of information that could inform the risk assessment and management process.

Holistic assessment requires more than a socially constructed assessment format such as the FAF; creating the right environment in an acceptable location and giving service users' the time to develop their answers to the questions put to them will contribute to the success of the process. The level of consistency in the themes emerging to these questions from both service users and professionals points to people needing to be aware of these issues when arranging an assessment.

6.3 Summary: Why is the FAF more Holistic?

How does the FAF make the assessment process more holistic? Referring to the definition that holistic means*'...parts of something are intimately interconnected and explicable only by reference to the whole'* (Oxford University Press 2016), to understand a service user in a holistic manner, we need to understand their parts as they are interconnected. That a socially constructed assessment guideline can achieve this has been supported by data from the interviews in this study.

As a boundary object, (Star and Griesemer 1989), the FAF is accessed and has access to information from different social worlds on a micro, meso and macro basis. Rycroft-Malone et al used a conceptual framework for their study that reflects this method, (2011 Fig.1 p3). The micro element includes those directly involved in the assessment process, i.e. the service user, referrer and assessor. The meso element includes the particular teams, such as the forensic CMHT, the referring CMHT, hospital or prison in-reach team. The macro element can include organisations such as those in the Criminal Justice System, Social Support Services, Community Services and Universities. Open access to the information in the FAF is available to those at the micro level during the assessment phase. Information can be provided at this phase by those at the macro level to enhance the holistic nature of the assessment. The meso level group can provide support in completing the report following the formal assessment stage. During formulation following assessment, the

meso and macro level groups will have an input to support the planning of interventions and services to meet the assessed needs.

These groups are shown in Table 8 below:

ACCESS LEVEL	GROUP					
MICRO	**Service User**	Prison	Community	Hospital		
	Referrer	Prison	Community	Hospital		
	Assessor	Psychiatrist	Psychologist	Social Worker	Nurse	Occupational Therapist
MESO	**Psychiatric Team**	Forensic CMHT	General CMHT	Prison In-reach	Hospital	
MACRO	**Criminal Justice System**	Police	Probation	Prison	MAPPA	Courts
	Social Support	Family	Carers'	Advocacy		
	Community Services	Housing	Addiction	Employment& Benefits	Social Services	Voluntary agencies
	Education/ University	Research	Supervision	Development	Courses	

Table 8, Conceptual Framework of Social Worlds

Each of the main groups in this study will be summarised in turn and then the overarching evidence to support the holistic nature of the FAF will be considered.

Service users appreciated that they were not seen as a collection of symptoms or risks but that their background and development was considered in detail to tease out the trajectory of their lives. They saw the process as one that was built on developing trust that was encouraged by the structure of the FAF which they saw as non-judgemental. This structure, developed from a critical realist perspective, ensured that all aspects of the individual were considered and that the interconnections between these aspects were also considered as a whole. By focusing on the individual service user and not the symptoms or risk, a holistic

approach develops throughout the assessment. Male service users saw the process as safe and comprehensive, with their needs picked out; female service users felt that their background and development was considered leading to an accurate life story and understanding of their schemas. The viewpoints from male and female service users reflect the differences between these two groups. The male service users need to feel safe in a process where they are generally uncomfortable in talking about issues usually avoided, such as emotions. In several assessments completed, service users needed to complete some basic psycho-educational work on understanding feelings and emotions, such as the alexithymia intervention suggested by Mary Jinks, (McMurran and Jinks 2012), before they feel confident that they have the language to express how they feel or felt in the past in completing the FAF process. The female service users rarely had this problem and appreciated the level of detail in the FAF process as it looked at their background and development in detail.

Referrers stated that the assessment process using the FAF was in-depth and not event focussed. The prison based referrers also appreciated the level of detail gained in the subsequent reports. Community based referrers felt that the process was supportive and promoted good communication between teams as they felt involved and included. The level of detail provided by the assessment informed formulation of intervention plans. Referrers stated that the structure of the FAF empowered service users to disclose difficult issues as they perceived it as a safe process. The in-depth elements of the assessment were seen to be enhanced by the ‘step back’ from events that led to generative forces being identified during the assessment. The structure of the FAF was seen to directly gain more background and development information from the service user which led to the identification of, for example, triggers to risk behaviours. The FAF was also seen as a pathway to further specialist assessments; this was an aspect of its ability to be based in the macro and micro worlds of consistent assessment approach that had the flexibility to respond to individual needs. The differing needs of the prison and community based referrers is reflected in their responses to this question. Prison referrers and community referrers both appreciated the in-depth and non-event focussed element of the FAF assessment that make it holistic, but the prison referrers wanted the information accessible due to their understanding that the service user could be

released or transferred to another prison at any point. Inter-prison transfers in the high secure estate are regular occurrences, particularly with '*difficult to manage inmates'*. Community referrers are more focussed on support and communication following assessment. This may involve clinical supervision or a period of joint working following the formulation of needs phase, or may simply be occasional reassurance through a telephone call. Keeping lines of communication open as part of the boundary object process reinforces its development through cooperation even if consensus cannot be agreed, (Star 2010 p604)

Assessors generally stated that the FAF was an excellent framework for assessment, noting that its structure led to the building of a level of trust and rapport with the service user. It was seen as a consistent multi-disciplinary assessment process that led to a more holistic approach. As a 'whole person' approach and a rounded assessment that had an open ended flexibility, service users were encouraged to use their own words to describe how they fit into the world and perceive themselves as individuals. The psychiatrist saw it as adequate, but constructive and useful. He would seem to have a wish to complete assessments using the medical model he is more used to. Accepting a multi-disciplinary assessment method was harder for the psychiatrists in the team as their role has moved from leader to partner over the past few decades in forensic psychiatry. In forensic psychiatry, the role of Responsible Clinician under the MHA 1983 generally lies with the psychiatrist, (Department of Health 2008), and they are responsible for providing regular progress/ update reports to the Ministry of Justice, along with the Social Supervisor, a process that has now become a joint report, (Ministry of Justice 2016). The psychologist, used to using psychologically informed actuarial assessment tools, appreciated the structure and rounded methods of the FAF in gaining a holistic assessment. The social worker appreciated the structured but open ended approach that looked at the whole person reflecting his professions location in a social model of care. The nurse had a more pragmatic response to the question in this chapter as she appreciated the focus on the micro elements of seeing the person as a whole, in their own words reflecting the nursing agenda of assessing, planning, implementing and reviewing care pathways.

The comparator group discussed achieving meaningful assessment for the service user and felt that this was achieved through the relationship they developed with them over several months. Their assessment process was prescriptive due to their use of the primarily psychologically informed assessment guidelines decided by the Ministry of Justice and the Department of Health and including the *IPDE/ HCR20/ PCL-r*. They felt that they did have a holistic approach although this was focussed on the individual skills of the assessor rather than by using a process, such as the FAF, which will consistently encourage a holistic approach to assessment. The assessment was seen more as a service to the referrer that provided information for government departments and that the service users were not their only focus.

All the groups in this study expressed various negative recollections of previous assessments they had been involved with. The reasons for this generally involved a lack of validated assessment guidelines, lack of or pressure on time, poor working practices and symptom or risk based assessment protocols. Service users generally had negative experiences in previous assessments which they felt looked at them as problems to be medicated. Referrers felt that previous assessments by other teams were seen as looking at the presenting risk in isolation, sometimes being prejudicial and making assumptions. These previous assessments can sometimes see service users as a set of symptoms rather than as an individual. The referrers also said that their experience of assessment was that they focused on symptoms and risk rather than the service user as an individual. Assessors felt that previous assessment models were not as holistic as the FAF and focussed on particular areas or models, such as the medical model. The need for a socially constructed model of assessment in forensic psychiatry, such as the FAF, is supported by people's previous experiences of other models of assessment. In general, people's experience of previous assessments is that they do not have the level of detail given by the holistic approach offered by the FAF and that they were not boundary objects accessible as bridges for information to pass over between different social worlds, (Star and Griesemer 1989).

The Forensic Assessment Format is shown in this chapter to be a boundary object that can be considered to have a holistic approach by the people interviewed who have experience of it. As a method developed from critical realist theory, the

material-discursive-intrapsychic model, the FAF considers all the aspects and experiences of an individual without privileging one above the other. The structure it provides to the assessment process is seen to build trust and a safe environment for the service user, who is assessed as a whole person not simply a collection of symptoms or risks. The way the service user interacts with the world is considered and an in-depth analysis of all aspects of the individual is presented in a multidisciplinary manner with information gathered from across social worlds by the FAF as a boundary object. This process is shown to be holistic in its endeavour to gain a critical assessment of the individual service user.

Chapter 7 Findings: Question 3

What are the processes influencing outcomes for service users when using the Forensic Assessment Format?

7.1 Introduction: Outcomes:

How does the Forensic Assessment Format benefit outcomes for service users? Is it the collaborative nature and the holistic structure of the FAF, as discussed in the two previous chapters, which informs the formulation of interventions leading to positive outcomes following assessment? As a boundary object, the FAF acts as a bridge for information to pass between different social worlds, (Kimble, Grenier et al. 2010). This results in the FAF empowering multidisciplinary formulation following assessment leading to a plan of interventions that will empower the service user to reduce risks and increase protective factors such as coping strategies, activities and support networks, both personal and professional. The benefit of using the FAF will be that outcomes have been improved for service users and referrers and that communication between the social worlds involved will also be enhanced, (Star and Griesemer 1989). This chapter will explore themes that emerged from the interviews in response to the third question set out at the proposal stage of this research project concerning outcomes, and will then present the resulting findings.

7.2 Theme – Processes Influencing Outcomes:

Each of the groups involved in this study had their own responses to this question, with differences evident within those groups as detailed in Table 9 below. Male service users felt that their needs were met, and that feedback was positive. A summary of the report would be appreciated rather than a copy of the full report. Female service users felt that the outcome was that they *got things out*, by which they mean that they were given an opportunity to express difficult and traumatic events from their past in a safe environment. They also said it helped them to receive medication and they appreciated receiving a copy of the report. Referrers in

the prisons said that the service users' needs were met, the report was in-depth and they appreciated the feedback they received. Community referrers appreciated the clear management plans and treatment recommendations along with clinical supervision, when indicated. The assessors felt that the service users' needs were met, but that sometimes the recommendations could be unrealistic. The comparator group staff felt that their direction was unclear in that they were unsure who they were working for, funders, referrers or service users. The service user in that group did feel that it was a positive experience.

THEME	GROUP	SUB-GROUP	DETAILS		
OUTCOMES	**SERVICE USERS**	**Male**	Summary report	Needs met	Feedback
		Female	Copy of report	Medication	Get things out
	REFERRERS	**Prison**	Needs met	Feedback + copy report for SU	In depth
		Community	Clinical supervision	Clear treatment recommendations	Management Plans
	ASSESSORS	**Psychologist**	Service User Needs met	Follow up reviews	
		Social Worker	Time given	FAF leads to needs being met	
		Psychiatrist	Feedback from SU	Unrealistic Outcomes	
		Nurse	Reviews	Unrealistic recommendations	SU needs reflected
	COMPARATOR GROUP	**Service User**	Felt better	Options considered	
		Assessors	Dual function	SU needs not always met	Prefer MDT approach

Table 9 Question 3 Themes

7.2.1 Female Service User Perspective:

Service user 1 felt that felt that the outcome of the assessment was that she was prescribed the medication that she needed, not just what she may have asked for. She felt that her view of her needs was included when outcomes were considered.

She appreciated receiving a copy of the report and felt that she had support throughout the assessment process.

Interviewer Do you think it went anywhere to meet your needs, what we talked about?

SU 1 *Well obviously, it got me the medication I needed from you, from you obviously talking to (Dr Y)...I feel that when I do go outside into the community, I just think that I can prove to psychiatry that I can just see, one to one.*

Not only did service user 1 feel that she achieved a positive outcome, but she felt empowered to engage confidently with community services following release from prison, which she has found difficult in the past due to her history of substance use. The prison environment where inmates are constantly seeking medication from the GP services can result in genuine service users with mental ill health having difficulties being prescribed appropriate medication.

Service User 4, who was low in confidence and social skills at the time of assessment, appreciated the way she was supported through the assessment and that it came to the right conclusions, meeting her needs and providing an opportunity to get things out. She appreciated seeing the finished report and offering some feedback. The idea of a follow up to see if recommendations were acted upon appealed to her.

Interviewer Going through all this assessment process and getting the report, how did you feel about it generally?

SU 4 *It was a good thing, brilliant*...*Get things out.*

'Get things out' for service user 4 involved discussing elements of her past, including sexual abuse, which she had not previously disclosed. She required many short sessions to complete the assessment, building trust and rapport and contributing to the agreed outcomes that revolved around building self-esteem and confidence and moving towards cognitive behaviour therapy to look at her thinking skills. The format and flexibility of the FAF approach supported this process. One of the social worlds accessing the bridge of the FAF as a boundary object was the prison wing on which service user 4 lived. Her female personal officer offered her support and encouragement to complete the assessment process.

7.2.2 Male Service User Perspective:

Service User 2 felt that although he got feedback from the assessment, he did not want a copy of the report as he was concerned that other inmates may see it. In previous assessments, recommendations were not followed up and they just wanted to give him medication to get him out of the room. He felt that the MDT approach helped the report to reflect his needs. Feeling safe in relation to confidentiality was important to him as he found trusting people in prison difficult. He felt that involving his personal officer in the assessment to some extent would help them to understand him more. From his perspective, he was asked about his needs and felt that the report did reflect them.

Interviewer OK, how do you feel that the outcome of the assessment met your needs, and were you given the opportunity to give and receive some feedback to and from the assessors?

SU 2 *I got some feedback from yourself, to a degree it was determined that I need to see a forensic psychologist to talk about things that have came through, not only in the assessment, but what came after the assessment*.

The format of the FAF allowed service user 2 to feel that he participated in developing the outcomes from the assessment and that these outcomes would help him. He does not blame the mental health team for the prison not acting on those recommendations.

Service User 3 felt that the assessment met his needs as far as recommending where he should go next and that it was accurate and would help him. He appreciated the opportunity to give feedback and make corrections to the report. Having a copy of the report was positive, as would be a follow up to check that recommendations were acted upon. He liked the MDT approach and felt that he was asked what his needs were. He could see no faults in the report and could see that the summing up pointed to things that would help him

Interviewer Was your experience that the report accurately reflected you as an individual?

SU 3 *It did, it's hard to describe this, because it was accurate, and at the end, the summing up did point to things that I knew helped me, my detention, my schizophrenia and to address my personality disorder.*

Service user 3 appreciated the accuracy and comprehensive nature of the FAF report that led to outcomes that he agreed would help him. He found that this

contrasted with his experiences with mental health services in the past that tended to focus on his current symptoms and presentation rather than looking at underlying causes.

Service User 5 felt that he should have had more information after the assessment and did not feel supported by his local team. He did feel that the report reflected his current needs. He was not keen to have a full copy of the report but felt that a summary would be useful, as would a follow up to assess if the recommendations were followed. He feels that he could have had some more support and clarification about the process.

Interviewer Did you understand what was going to happen, what happened on the day and what happened afterwards?

SU 5 *I could have done with a bit more information afterwards like. People were a little bit cagey, as explaining, er, what the point of it was, you know what I mean when I was asking; they were saying, er, oh, we can't tell you, you'll have to wait until you've been assessed before we can give you any information....Basically it's, erm, it's helped* (the report)*; it's helped us basically get, erm, get towards leaving, things like that. Stuff that I needed, you know what I mean?*

As noted previously with service user 5, his experience of assessment was that it was in a poor environment with little warning or explanation about the assessment process. That he could understand that the outcomes of the assessment could help him supports the proposition that one of the benefits of using the FAF is that it can be inherently effective regardless of other elements associated with assessment, such as location and service user awareness of the assessment taking place.

7.2.3 Summary: Service Users' Perspective:

The service users felt that there were benefits for them in using the FAF for the assessment process. The gender differences in their perceptions of the processes involved in achieving helpful outcomes were interesting. The female service users saw the process as an opportunity to discuss issues from their past, to *get things out*. The male service users felt that the outcomes met their needs and that they were listened to when expressing their perception of their needs. Building trust with the assessor was seen as important when making recommendations and discussing

this in a feedback session was seen as helpful. They liked the confidentiality of the process being clarified at the start and that they were asked to go through the report with the assessor to correct any factual errors. Most service users', regardless of gender, would like a copy of the report with one service user suggesting that he would have preferred a summary of the report as the full report was too long. They also felt that the FAF allowed a level of context to be added when summarising their presentation. Having a review meeting after a period of months was seen as positive as progress with the recommendations could be reviewed. It is worth noting that the female service users generally had a history of substance use following trauma, usually involving family and relationships. The male service users, other than service user 5, had a history of perpetrating extreme violence on others, including female victims and were initially not comfortable discussing their emotional reactions to these events.

7.2.4 Prison Based Referrers Perspective:

Referrer 1 felt that dissemination in the prison needed to be clear around how the recommendations impacted on care plans. Feedback to the referrer following assessment and a later review to gauge progress is seen as helpful. She perceives the feedback she receives in the FAF informed forensic report as holistic and it encouraged her to assess service users in a similar manner.

Interviewer I mean is there any way we can involve the (prison) staff more because in some ways if in a community placement they would be seen as carers and would be involved in the CPA process?

Referrer 1 *They could be invited to the multi-disciplinary team meeting...There should be more people if they are involved with them, even the likes of say the chaplain so that they could be doing bereavement counselling or any type of counselling or even psychology so that we have got a more...*

The holistic and collaborative approach used by the FAF encourages referrer 1 to want to include all the people having contact with her service user to be involved in the outcome plan following an interdisciplinary formulation meeting. This expansion of the social worlds involved with the FAF as a boundary object can expand where indicated, involving in this case the prison chaplain service.

Referrer 2 felt that the FAF was more in depth than other assessments and that it puts the service users' experiences into context. He liked the idea of follow up reviews to ascertain if recommendations were acted upon. Having a comprehensive assessment report on file was seen as a positive outcome of the assessment process.

Interviewer What is your opinion on the amount of detail the assessment interview went into?

Referrer 2 *...We are conditioned, and the forensic assessment, when you actually spend more time with... you, you look at the person, objective and subjectively and hopefully you get a formulated outcome...To me the referral process, once you've actually put it in and they've been seen, the document is excellent a lot more in depth than what we would normally see... it gives us more stuff to refer back to as well, it's there, it's there. On the next admission we've got the full documentation, everything that she's been through etcetera, everything that could be found she's been through...The outcome...made loads of recommendations such as referral into MAPPA and giving MAPPA some guidance...*

Referrer 2 discusses the FAF's ability to achieve a *formulated outcome* that makes *loads of recommendations* and also provides *full documentation* in place for subsequent admissions to his service. Again, the ability of the FAF to act as a boundary object and provide bridges between different social worlds for information to pass over, such as MAPPA, is emphasised. This referrer feels empowered by the information provided in the FAF report, he understands that if the service user is readmitted, all the necessary information on her mental health will be available.

7.2.5 Community Based Referrers Perspective:

Referrer 3, a consultant psychiatrist, feels that some referrals to the forensic service are a matter of referrers '*covering ones back*' and passing the patient on to forensic services, but his experience is that he was satisfied with the outcome of the FAF assessments in terms of identifying a management plan to look at risk issues. He felt that having some initial feedback in the days after the assessment, prior to the full report, would be helpful. He likes the idea of checking the report with the service user and providing the service user with a copy.

Interviewer Do you think that it might be better then, to provide more information to staff involved with the service user?

Referrer 3 *...One of the moans I often hear from some who have referred in my general adult colleagues is that it takes ages to do, and what does it achieve? Again, I think the*

agenda behind that is please, take this person away from me and I don't ever want to see him again. And can you manage them so I don't have to think about them in the near future.

The assessor needs to be aware of the possibility that the outcome the referrer is seeking is for the forensic service to take over the care of the service user referred and that the service user may not appreciate the recommended interventions. The way the FAF is not influenced by issues such as these due to its structure being built on a model from critical realist theory and that it collaboratively and holistically assesses service users in a comprehensive manner to achieve its outcomes; in this case identifying a risk management plan.

Referrer 4, a nurse, appreciated the way the outcomes of the assessment are fed back and feels that the communication through case formulation at a review is worthwhile. She felt that offering clinical supervision after assessment was of great benefit to a team not used to working with people who pose risks to others due to mental disorder.

Interviewer Looking at outcomes, did you feel that the outcome of the assessment met the needs of the service user you referred?

Referrer 4 *I think that is a very difficult question to answer actually, erm, because...if you were to ask him what he felt his needs were, they wouldn't match with what we thought his needs were. There was some stuff that came up from the forensic assessment, what the recommendations were, that, although I can see why the team were suggesting those interventions, I felt that, erm, the interventions could possibly cause harm to my relationship with the person if I attempted, erm, to follow, erm, those recommendations.*

Referrer 4 highlights her generally positive experiences with assessments using the FAF but also states that there can be contradictions in perceived needs among all those involved in the process. The assessors will look at the needs of the service user to meet the issues and opportunities highlighted in the assessment. The service user may have a different perspective influenced by, for example, experiences or mental disorder and the assessor focuses on the therapeutic relationship they have with the service user. On-going support and clinical supervision or advice from the forensic service is appreciated in this set of circumstances. A suggested method of understanding the way people perceive then process and project their version of reality will be considered in the discussion chapter. In the specific case she mentions, involving other agencies in the outcomes, such as child protection,

MAPPA and employers was recommended putting pressure on her therapeutic relationship. Accessing different social worlds through the use of a boundary object, such as the FAF, can be a difficult process at times.

Referrer 5, a nurse in a community addictions service, appreciated the clarity of the outcomes of the assessment. She saw positive aspects of the service user having a copy of the report, such as reassurance, taking ownership and being empowered. Having the possibility of follow up from the Forensic CMHT was of benefit if the service user's presentation changed or to assess the impact of implementing the recommendations. She felt that the outcome of the assessment reflected the needs of the service user from both his perspective and hers.

Interviewer Looking at outcomes, did you feel that the outcome of the assessment met the needs of the service user you referred?

Referrer 5 *I did, the recommendations were very precise, but it's around what we thought we have available within the Trust...It did reflect the needs and again I can only say that it didn't focus on the substance misuse and it was a full picture of his, erm...family background, mental health history, psychological presenting problems and there was a clear outcome and a clear risk assessment. And the risk assessment was very useful...Again, it was very detailed and very individualised, very client centred; but also it was very...because the issues he was talking around were very sensitive, it was very respectful and presented in a way that was positive and it's enabled the client to put in perspective a number of issues and begin to move forward...seeing it written down and seeing a clear plan, I think gave reassurance to him.*

Service users who have personality disorders can be excluded from treatment in some circumstances; having an assessment that makes clear treatment recommendations can empower the referring team to access appropriate interventions. The outcomes of the FAF assessment are perceived as *precise* and giving a *full picture* in a *sensitive* and *respectful* manner leading to this referrer appreciating the accuracy and sensitivity of the FAF. Contextualising the service users presentation helped to put the service user's issues into perspective in a positive way that empowered him to move forward.

Referrer 6, a social worker, felt that the outcome of the assessment met the needs identified in the referral. He did not seem to consider whether the service user should be provided with a copy of the report but did see follow up positively, if peripheral to ongoing case management within his service. The MDT approach was seen as

positive and he also felt that the service user's needs were met by the assessment, from both the referrer's perspective and the service users.

Interviewer Was it your experience that the report accurately reflected the current needs of the service user you referred?

Referrer 6 *I would say so, based on the delicate nature of his needs. I think that was primarily focused on where our own team focused more on the mental health needs of the client but also taking into account that the mental health, or whatever, of his offending behaviour was sort of interacting with that to a certain degree. So I believe from that perspective, I think the additional assessment by the forensic community mental health team, and some of the options looked at, I think were suitable to the client's needs...which involves writing to the GP to apply for funding for specialist assessment for that person...And I do discuss with him, quite delicate needs that focus on his care plan...*

Referrer 6 appreciated the ability of the FAF assessment to suggest extra options, such as referral to a specialist sexual behaviour service. The outcome of the assessment led to a plan of care that put his 'delicate' issues on the agenda for discussion at reviews. By assessing the service user using the FAF, the way his mental health and offending behaviours interacted was better understood and a way to meet the intervention needs to reduce his offending behaviours was formulated.

7.2.6 Summary, Referrers Perspective:

The prison based referrers appreciated the feedback and recommendations they received from what they saw as a comprehensive report that provided a full history of the service user that would be useful during their periods of incarceration. They felt that the process encouraged an interdisciplinary approach, involving other people outside of the mental health team in the prison. The community based referrers appreciated the precise and sensitive treatment recommendations that assisted the formulation of a risk management or intervention plan that led to a better understanding of the relationship between mental health and offending. Ongoing support from clinical supervision following assessment was seen as helpful.

The referrers all felt that putting the service user's history, experiences and motivations into context informed the relationship between the service user and professional and allowed a positive way forward to be planned. The idea of a review

after some months to assess progress towards achieving the recommendations was also seen as positive. The issue of access to treatment for people with a diagnosis of personality disorder was raised by one referrer who felt that the report empowered his team to access that treatment. This aspect was also supported by referrer 6 to access specialist assessment for sexual behaviours for his service user. The issue of service users and referrers having different ideas about outcomes is countered by the FAF structure using the material-discursive-intrapsychic model and not being influenced by subjective issues. The referrers may have initially sought an assessment as a way for the forensic CMHT to take over the care of the service user referred, but as a boundary object, the FAF encouraged them to connect with other social worlds for support, such as chaplaincy, MAPPA, employers and social services. These connections to other macro level social worlds offered new avenues to inform formulation and outcomes.

The way people perceive then process and then project their version of reality will be discussed further in the final chapter and a method of understanding this process, *realtà proiettata* will be offered.

7.2.7 Assessors Perspective:

Assessor 1, a psychologist, felt that the FAF helps to put events into context which leads to the recommendations being related to the service user's needs. Offering follow up helps both the referring service and the Forensic CMHT assess the impact of the assessment. Involving the service user in reflecting what their needs are should impact on the outcome of the assessment.

Interviewer	Outcomes, did you feel that the outcomes of the assessment met the needs of the service user?
Assessor 1	*What I like to do is to make sure that any recommendations that I make or that we make, equate to what their needs are; but I think that there is a slightly different issue if you take that one step further because, quite often you are asking other teams to meet those recommended needs almost on an advisory, or on your behalf, and whether they've then met those needs with that patient is perhaps a research issue for later on down the line.*

Looking at outcomes, assessor 1 feels that they are related to the assessed needs identified during the FAF assessment. How, or even if, those recommendations are implemented by the local service is not guaranteed simply by the report suggesting them. So in terms of absolute outcomes for the service user, further research is indicated on this point.

Assessor 2, a social worker, felt that the Forensic CMHT has the benefit of time to consider recommendations. Follow up is seen as an opportunity to see what happened after the assessment as well as support for the referrer and service user. The feedback of the assessment report and recommendations to the referrer and the service user is also seen as a two way process. He stated that sometimes the needs identified by the FAF assessment are not the ones the service user expected, but the format of the FAF helps to cover the identification of needs thoroughly, and also includes the service user's perspective. Going through the report with the service user gives them an opportunity to correct any errors and to be part of the process not just the recipient of the recommendations from the assessment.

Interviewer Looking at outcomes, did you feel that the outcome of the assessment met the needs of the service user?

Assessor 2 *I suppose it depends what you mean by needs. Sometimes the needs we identify are not the ones the service user wants us to identify. And we maybe highlight risks or concerns that they haven't recognised, or maybe their team haven't...Again, the service users, I'm not sure that they always want it, to see these needs identified, but for some, it's a really useful process, maybe not on the day, but see what comes from it afterwards, the treatment, the possibilities of a better way to manage their risks, 'cos it's about them...that's another benefit of the time we get to make our own assessments in the forensic team. You're actually given a bit of space to think, cogitate and think up all the angles and, together, form an opinion and have a plan that you can then impart to the people on the ground...*

Assessor 2 raised issues around the time that assessors in this process have to consider their recommendations. In other teams, caseloads may dictate that time is not available to give such consideration to each particular service user. He feels that the assessment also remains focussed and is not influenced by the opinions of service users, referrers or assessors when considering needs due to the design of the interview schedule. That the main focus is the service user is supported in his thought that *it's about them* even though the needs identified may not necessarily be the ones seen by the service user at the time of assessment. The service user may want to externalise outcomes by, for example, feeling that the support he receives is

not regular enough or that he needs more state benefits when the outcome of the assessment is that it is the service user who needs to commit to accessing psychological interventions.

Assessor 3, a psychiatrist, felt that sometimes the referring team can have unrealistic expectations about the outcome of the assessment and may be disappointed. He feels that the service user, on the other hand, can be *'pretty happy'* as they have at least had some people sit down and have a chat with them. He questions the ability of the Forensic CMHT to consistently summarize the service users' needs and how to meet them in the reports we provide. He would like more service user feedback and to know whether the assessment made any difference. He finds the concept of the service user having a copy of the report acceptable, but that the final decision should be by the service user's own clinical team, based on clinical presentation. He accepts that service users should be asked for their opinion on what their needs are and that we ask that question as part of the FAF assessment.

Interviewer So maybe we need to split that question into two; do you think the referring teams are achieving their outcomes from our assessments?

Assessor 3 *If the question there is how realistic are the referring teams expectations, because from my perspective, too often, it is we are a 'rubber stamping device'; or we are a erm…'cover our backsides device'; or we are a 'Christ, we are seeking divine guidance 'cos we don't know what the hell to do with this person'. And in all three of those circumstances, they may well end up feeling disappointed because they are not so likely to get what they want from us... (*What the service users perspective) *is, and it sometimes it's for people to sit down and have a chat with them and actually to think about things then I think they would feel that at least that has happened.*

Assessor 3 feels that the expectations of the referring team should be managed as the outcome may not be what they were expecting. The FAF has a set structure that is designed to extract the needs of the service user, which may not coincide with the referrers' perspective. He would like to understand if the outcome of the assessment was implemented and did it make a difference. The process of assessment, at its simplest, is *to sit down and have a chat* with the service user, an outcome in itself. A process such as the FAF may be the first time someone has actively listened to the service user and attempted to gain a full understanding of all their experiences in a structured, holistic and collaborative manner. The information bridges created by the boundary object element of the FAF need to be kept open after assessment to provide feedback on the efficacy of the outcomes recommended after formulation.

7.2.8 Summary, Assessors Perspective:

The assessing clinicians from the Forensic CMHT consistently refer to the ability of the FAF to contextualize events leading to a more rounded understanding of the service user. This feeds into the outcomes of the assessment being formulated around the service users' needs. The assessors felt that the service user should receive a copy of the assessment report, with the psychiatrist feeling that the decision should be with the referring team. All the assessors felt that the service user should be given the opportunity to express what they feel their needs are. Gaining feedback from the referring team and service user was seen as a good thing but not always possible due to time pressures and other priorities. There was a level of concern expressed by assessors 1, 3 and 4 that the recommendations may not be carried out by the referring team following the assessment and that one of the outcomes should be a follow up assessment to review this area. There is consistency across professions in how the processes informing outcomes are perceived as service user centred. A common theme is the desire to know if the outcomes were acted upon and if they made a difference.

7.2.9 Comparator Group Perspective:

Service user 6 from the comparator group stated that he felt better about himself after the assessment and understood that he needed to share his experiences with the assessors, who he said that he trusted. He felt that he was treated as an individual, asked about his needs and given an opportunity to look at options for the future. He also felt supported by the assessors, but did not want his family to share the contents of the assessment and felt that they could not properly support him.

Interviewer	So do you feel this team helped you to do that, the way they ask the questions?
SU 6	*Yeah, I feel a lot better about meself, I still want to top* (kill) *meself and that, and top other people; however, I feel a lot better...Well, I think it's important to get everything out, and then from there...sort me head out; try to make it better or something...That's what we are looking at now, options and stuff for the future.*

Service user 6 stated that the process he went through for his assessment, lasting many months, allowed him to develop a level of trust that has led to options for the future being considered. That he disclosed the thoughts he has regarding harming himself and others, which he has not acted on, is a positive outcome.

Assessor 5, an occupational therapist from the comparator group, felt that she had responsibilities to three groups, the referring team, the service user and the Department of Health/ Ministry of Justice who provide the funding for their service. The later need facts and figures about the work they do, including the rate of completed episodes of assessment and treatment, which she notes are about one in four of those referred to their service. She feels that the service users need to know if they can be helped to get better and to understand their feelings and then have an opportunity to discuss the recommendations at length. The comparator group offer a monthly Patient Progress Update to referrers which give feedback on the main issues arising that month. She reports that referrers like the reports that they provide, however, she is not sure how good they are at getting feedback from service users. The assessment process is comprehensive, using several assessment guidelines and psychometric tests, including the International Personality Disorder Assessment, IPDE, (Loranger, Sartorius et al. 1994); Historical, Clinical, Risk Management-20 (HCR-20), (Douglas and Belfrage 2001); and Psychopathy Checklist–Revised (PCL-R),(Hare 1991) all of which she feels help to contextualize events. She stated that the assessment does not meet the needs of '*quite a significant number*' of service users but that it identifies all the current needs well including those identified by the service user. The report can be very lengthy so their service offers the service user a feedback booklet to summarise the main points.

Interviewer	What I would like is both, I would like to hear about your experience of the (*assessment*) process now, and how you felt about it in the past.
Assessor 5	*...Our assessment process now is vastly different because, I think it's because of that dual function. What the Department of Health and the Ministry of Justice really want to know is, kind of, facts and figures, I think, a lot about risk and are we worth the money actually that's been spent on us...from the service user point of view, I guess they're going to think, can you help me get better, can you explain why I am feeling like this.*

Assessor 5 states that a lot of the outcomes from the assessment are geared towards generating statistics for the Ministry of Justice and the Department of

Health. She concedes that most service users would prefer an assessment over a couple of sessions so that they can move towards interventions more quickly, as is the case with the FAF assessment. The report generated by this long and involved process of assessment is said to be comprehensive.

Assessor 6, a nurse from the comparator group, felt that the outcomes from their assessment could be perceived as not being service user focused, but more about protecting the public from a risk that the service user may present, which may not please everyone. The assessment is presented to the referring team and they get an opportunity to discuss it with the assessors. He confirmed that follow up sessions have not been considered. He feels that the assessment contextualizes events by getting the service users perspective in their own words and by gathering background information from as many sources as are available, including family and previous health records. The MDT approach adopted gathers different professional perspectives. He stated that he checks with the service user that their needs are being met and that they are happy with the service. He feels that a service user copy of the finished assessment report needs to be carefully managed and presented.

Interviewer Did you feel that the outcome of the assessment met the needs of the service users?

Assessor 6 *Erm…it's…working in a forensic service, erm, it's an interesting…you're stuck in a little bit of a…erm…there's a dichotomy I suppose, in terms of, you know, who you serve ultimately, and as much as we provide mental health care to patients, erm…and as much as we will look at meeting their needs as much as we can, we also have a public protection, erm…remit, which means that sometimes the outcome of our assessment is about protecting the public, which, sometimes, is at loggerheads with what the patient wants to achieve.*

Assessor 6 stated that the commitment his teams assessments have towards public risk protection is at loggerheads with meeting the service users' needs. He said that he contextualises the service users' background by gaining information from various sources, such as family and GP. The individualised nature of the reports his service provides are dependent on which professions were involved in the assessment process. He expressed some concerns concerning the service user having a copy of the report. This focus away from the service user and towards the referring team and public protection will be discussed in the summary of this chapter.

7.2.10 Summary, Comparator Group:

Service user 6 from the comparator group felt that the outcome of the assessment was that options were being considered, and that he had not acted on his thoughts to harm himself or others. The comparator group staff had differing perspectives on outcomes from their assessments; they felt that the protection of the public and providing facts and figures for their funders, Department of Health and Ministry of Justice, required them to have a different agenda. Assessor 5 stated that only one in four service users complete assessment and treatment with their service. As the assessment process is lengthy in the comparator group, they provide monthly feedback reports to referrers summarizing progress. She feels that the assessment guidelines and psychometrics they use provide a comprehensive assessment that contextualizes the events and experiences of the service user. She also accepts that this process does not always capture all the needs of 'quite a significant number' of service users assessed by their service. They offer a summary of the report for service users in the form of a booklet and also said that service users would prefer a quicker assessment process that allows interventions to commence earlier. Assessor 6 from the comparator group states that their report is fed back to the referring service at an MDT meeting to allow discussion. He feels that their assessment report contextualizes events by getting the service users perspective and information from all available sources. He stated that the assessment benefits from having the perspective of different professionals. He went on to talk about outcomes focusing on public protection and the needs of the referring team rather than the service users' needs. A copy of the report may be provided for the service user, but he feels that this needs to be carefully managed.

The main theme from the comparator group assessors concerned public protection and risk management as being a separate entity and focus from the service users' needs. In contrast, the FAF focuses on gaining a collaborative and holistic assessment to inform formulated outcomes that meet the service users' needs that could lead to the service user becoming more socially included with a potential reduction in recidivism and readmission rates.

7.2.11 Jon's Perspective: Outcomes

From my perspective as an auto-ethnographic researcher in the service under study, I feel that the FAF does have benefits in relation to outcomes for service users. As the FAF allows a comprehensive assessment of every aspect of the service users' presentation, including contextualizing events that led to a referral to the Forensic CMHT, the recommended outcomes of the assessment link directly to the service users' needs. The referring service is also supported with implementing the recommendations through follow up reviews, clinical supervision or joint working. Having recommendations from the Forensic CMHT adds weight to requests for interventions being made available to service users. An example would be an onward referral to a specialist service, such as the Sexual Behaviour Unit, which was a regional specialty service which offered assessment and treatment of problematic sexual behaviours; this service carries a significant cost to the referring service. Other examples may include Dialectic Behaviour Therapy, DBT for a service user with a personality disorder, (National Institute for Health and Clinical Excellence 2009b); Eye Movement Desensitisation and Reprocessing, EMDR, for a service user with Trauma issues or PTSD, (National Institute for Health and Clinical Excellence 2009b). These specialist interventions may require onward referral and having a comprehensive assessment of needs available, such as that provided by the FAF has aided service users accessing these treatments with support from commissioners where necessary.

In my experience of prison based assessment using the FAF, service users appreciate the chance to talk with someone outside of the prison system who they perceive as independent. They accept the confidentiality riders imposed, i.e. that the prison authorities will be informed of any expressed threat to themselves or others or any plans to escape. The process of assessment in the dispersal prison system, which is high secure and for people serving long sentences, can then take as long as is needed to complete, allowing trust to develop as the material aspects are gathered. The outcome for the service user in this circumstance can be seen as a therapeutic alliance that gives them the space to contextualize their past. It may be the first time that they have tried to put into words their life experiences and understand who they are and how they fit into and react to the world around them. I

believe that this can be an empowering experience that can lead to improved self-awareness, self-esteem and confidence. Sometimes this can take several months to complete as it may be necessary for the service user to learn a new vocabulary so that they can better express their emotional reactions to the issues discussed.

> *One inmate in a dispersal prison had developed barriers to prevent him from engaging with the mental health system. His offence had resulted in a conviction of murder, even though he had a history of contact with mental health services that could have been seen as diminishing his responsibility resulting in him being subjected to a hospital order, Section 37/ 41 of the MHA (1983). He had refused to comply with his solicitor's advice and had defended himself at trial refusing to use a mental health defence to avoid a conviction for murder. Over a period of a year, with the support of prison staff, including his personal officer, I engaged with him on his wing, discussing his social interests which included a comprehensive knowledge of opera, in which I also have an interest. We developed a professional relationship that led to an assessment using the FAF which was eventually completed after many sessions. At times, these contacts may be simply exchanging a greeting in passing or comprehensive discussions on the operas of Handel, including the correct way to pronounce 'Giulio Cesare'. At this time he was eating very little and losing weight, isolating himself in his cell for long periods. The result was that he eventually shared his deep and complex system of delusionary thinking around witchcraft and the supernatural and went on to receive the treatment he needed following a transfer to a high secure hospital. Without spending that time with him, and the staff on his wing, this development could not have progressed and the collaborative and holistic approach of the FAF contributed to this outcome.*

The issues raised by the service users, who attended the focus group and pre-study interview, including the importance of outcomes, having the service user voice heard concerning their needs, feeling supported through the process, getting a copy of the report and having a review some months after the assessment to check that the recommendations have now been acted upon. I feel that the FAF contributes to these outcomes occurring and therefore does benefit service users in terms of the outcome of the assessment.

7.3 Summary, Outcomes:

In this chapter, data from the interviews have been presented and discussed in an effort to answer the third research question, what are the processes influencing assessment outcomes when using the Forensic Assessment Format? Outcome has been defines as *'something that happens as a result of an activity or process'*

(Merriam-Webster Incorporated 2016), the process involved in this study is an initial forensic assessment using the FAF and the *something* is the recommendations made following that assessment. Analysis of these data has identified several themes in the groups and subgroups concerning the benefits of using the FAF in terms of outcomes.

The female service users interviewed expressed several areas that they appreciated about outcomes following being assessed using the FAF. These included the perception that the events that had precipitated their referral were put into context and that they were listened to when expressing their thoughts about their needs. One felt that her confidence was improved as a result of the assessment and that she was empowered by the process. The male service users felt that their needs were reflected in the recommendations and that they participated in identifying those needs. The FAF was inherently effective at seeing past other agendas involved in referring to and being referred to a forensic service such as focussing on risk or mental health in isolation. Follow up reviews were supported by service users generally as the FAF could identify several potential interventions which were not always carried out by the referring service. Going through the report with the assessors to check for accuracy and being offered a copy of the report were seen as positives. The main differences observed between male and female service users in this study is that, generally speaking, female service users, particularly in the prison system, can be seen as *victims* with a history of trauma as children and adults centred around family and relationships. This trauma can lead to emotional disregulation, social isolation, substance misuse and acquisitive criminal activity. Male service users regularly have a history of aggression and impulsive thinking styles that can lead to violence to others. They are generally the *perpetrators* of traumatic behaviours to others, including women and children who progress along a pathway that can end up in the criminal justice system. Male service users tend to externalise their stress by inflicting violence on others whilst female service users tend to internalise their violence through aggression, suicide and self-harm, (Nicholls, Cruise et al. 2015).

The prison based referrers felt that the outcome of the FAF assessment could be inclusive and that it contextualised the identified needs. The in-depth nature of the

FAF assessment led to more formulated recommendations. They appreciated the chance to have follow-up reviews and having a comprehensive report on file was seen as helpful on subsequent admissions. Community based referrers felt that the nature of the FAF assessment gave them a *full picture* as well as *clear outcomes* leading to a comprehensive management plan. They saw the outcome as sensitive and respectful to the service user but there were some comments on whether the outcome would meet the referrers' need, which may include taking over the care of the service user rather than advising on management. The differing perception of needs between the referrer and assessing team are countered by the consistent approach of the FAF as discussed in the two previous chapters. Assessing the service user in a collaborative and holistic manner can help to identify interventions that avoid focusing purely on mental health and risk factors leading to a more formulated outcome. There was a general consensus between the referrers that the needs of the service user and the referring service were both met by using the FAF; the service user accessed appropriate interventions and management and the referrers accessed advice and support on how best to achieve them. They felt that putting events into context allowed a positive way forward to be planned. Feedback, formulation, clinical supervision and review are all elements that can follow the assessment and referrers found these areas positive and helpful. Accessing interventions for difficult to manage conditions such as personality disorder was supported by being recommended in the report following assessment. Referrers supported service users getting a copy of the report, having had input into checking it for accuracy. The main apparent difference between prison and community based referrers is that prison referrers saw the expansion of the macro connections inherent in using a boundary object, such as the FAF, as a positive experience and welcomed input from other social worlds, such as chaplaincy and MAPPA. The community based referrers were looking to forensic services to take over care of the service user and there was resentment in involving other social worlds in the community, such as MAPPA, Social Services and Child Protection, for example.

The assessing clinicians from the Forensic CMHT consistently refer to the FAFs ability to contextualize events leading to a more rounded understanding of the service user. They felt that this led to the outcome of the assessment, including the recommendations, being closely related to the service users' needs from all

perspectives, service user, referrer and assessing clinician. Gaining feedback from the referring team, including the service user, could be helpful in further developing and improving the assessment process. All felt that a copy of the report should generally be provided to the service user and that the service users' perspective on their needs should be sought. The psychologist questioned if the recommendations would be implemented and was positive about having review meetings. He felt that the process using the FAF identified the service users' needs which led directly to the recommendations. The social worker felt that time was a major factor benefiting the FAF assessment as there was a multidisciplinary contemplation of all the information generated by the FAF assessment. He felt that here were sometimes unexpected outcomes for the service user and referrer to consider due to the nature of the FAF assessment, but that these could be positive in the long term. The psychiatrist felt that the referrer may be disappointed by the outcome of the assessment but that the service user will usually have a positive experience, at the least it will have been an opportunity to be listened to actively. He also agreed that follow up reviews for all involved are a good idea. The nurse felt that follow ups were necessary to assess that recommended interventions had taken place. She also felt that the FAF could encourage inter-disciplinary working by drawing in extended groups to provide interventions.

Some differences between psychiatry/ psychology and the social work/ nursing professions became apparent during the study with social work/ nursing having more of a service user focus than psychiatry/ psychology who focussed on follow up and feedback. A theme across all the professions was that the increase in information flow across the bridges provided by the FAF as a boundary object were appreciated and nurtured.

There were some differences in the way the comparator group perceive their assessment process, they saw their outcomes as protecting the public and providing data to their funders but they did feel that the outcome of their assessment went some way in meeting the needs of the service user. The service user saw it as a long process that helped to build trust and consider options. The Personality Disorder element of the comparator group has a very long assessment period, running into months and has a 75% dropout rate on people progressing through to

complete the treatment element. They feel that the medico-psychological assessment guidelines and psychometrics that they use provide a lot of detail that puts events into context, but does not necessarily capture all the needs of the service users they assess. The focus of a lot of these assessment guidelines is around clarifying diagnosis rather than building a collaborative and holistic assessment of the service user. The nurse from the comparator group feels that the way the report is fed back to the referring service allows a two way discussion that is helpful in formulating interventions. He said that involving the service users' perspective of their needs is important. The comparator professionals expressed some reluctance to give service users copies of the full report, but agreed that the service users should have elements or a summary of it.

The processes influencing outcomes for service users when using the FAF include the design of the FAF itself that has been shown to be collaborative and holistic in the previous chapters. The way the FAF acts as a boundary object to bridge information flow around the social worlds involved is also seen in a positive light by all those involved. Another major influence is that it promotes macro connections and partnerships following assessment to achieve the formulated outcomes.

Chapter 8 Findings: Question 4

Can a collaborative approach to assessment assist the social inclusion agenda and if so how does involving forensic service users in the research process contribute to this?

8.1 Introduction:

This chapter explores themes from the semi-structured interviews and the focus group in response to the fourth research question concerning social inclusion. Service users referred to the forensic CMHT for assessment are subject to elements of social exclusion due to their mental health and risk status, (Madanipour, Cars et al. 1998), (Pilgrim and Rogers 1999 p167) and this is further compounded by the addition of a '*forensic psychiatry label'* which can exclude them from some general adult psychiatric services as they are perceived as being 'too risky' to be seen. It is suggested that the use of a socially constructed model of assessment, such as the Forensic Assessment Format, that assesses service users' in a collaborative and holistic manner can assist social inclusion by empowering service users' and enhancing confidence and self-esteem. The effect that the FAF, as a boundary object, has on social inclusion by opening up bridges of information flow between different social worlds as previously outlined will also be considered.

Including service users' at the design stage of a research study into forensic assessment does impact on their perceived social inclusion. They feel that they have engaged with social worlds, such as higher education, that they do not usually experience and have expressed an opinion that could influence future assessment techniques, (chapter 4.3.1.1). Service users who have previously been assessed by the FAF were motivated to discuss this experience in the semi-structured interviews for this study and expressed the thought that they felt that they were contributing to improving the process of assessment. That they were being asked for their opinion was seen as novel and some mentioned previous research studies they were aware of which were looking at past or present behaviours to inform risk assessment guidelines.

8.2 Social Inclusion:

This question has two elements: can a collaborative approach assist social inclusion and what contribution is made by involving service users in the research process. As discussed previously, (Chapter 1.1; Chapter 3.3), social exclusion is increased by offending behaviour and substance misuse, and the addition of mental health problems will exacerbate this situation. A large proportion of the service users at the heart of this study have influences on their lives from these three areas. The FAF is shown to engage with service users in a collaborative and holistic manner, see chapters 5 and 6 above, leading to the perception of being accepted as an individual not as a label, such as offender or mental health service user. The impact on service users' confidence and esteem increases empowerment as will be shown in this chapter. The main theme of this chapter is Social Inclusion and the group details are shown below in Table 10:

THEME	GROUP	DETAILS			
SOCIAL INCLUSION	**SERVICE USERS**	Empowered	Involved	Increased Confidence	Enjoy Research Process
	REFERRERS	Covering their back	Risk	Forensic Label	
	ASSESSORS	Service User involved	Risk	Service User Empowered	

Table 10: Research Question 4 Theme

8.2.1 Service Users Perspective

The service users' expressed a variety of views on a collaborative approach assisting social inclusion and being part of this research process. Some felt that seeing people outside of their usual environment helped with collaboration as they could be more open without fear of consequences, for example being seen by the mental health services in prison is seen as external to the usual systems they encounter.

Service user 2 feels that collaborating with someone who has no experience of committing his offence is difficult and that he should be given an opportunity to take the lead at times when being assessed. He does feel that he can talk about his offence related issues outside his usual environment and social group where it is less likely that he will suffer repercussions.

Interviewer Looking at the other assessment of your mental health, do you think they met your needs at the time?

SU 2 *No...They wanted to give me tablets; just didn't want me in the room. They didn't understand that once you've committed a murder, it's hard for you to come to terms with what you did. Er, you have like…I'm trying to say at the time, the smell of death was around you all the time. You can taste it in your mouth. A prisoner knows what that's called, you know, from others in for offences of murder. That's why I call…where do you go from there? Do you find that's quite calm? I haven't done enough suffering in the eyes of that family I'm charged with killing a member of.*

The exclusion of serious offenders from services, as described here, is countered by the collaborative way the FAF completes an assessment taking into account all the experiences of the service user. By using a socially constructed assessment guideline to gain a full picture of the service user a formulated response is encouraged that could meet the needs of the service user and reduces risks to others.

Service user 3, who has a history of serious substance misuse and psychosis, feels that his history of violence impacts on every interaction, regardless of his current lack of substance misuse and symptoms of psychosis.

Interviewer I wonder if you could tell me a little bit about the assessments you have experienced in regards to your mental health?

SU 3 *As you know, I suffer from paranoid schizophrenia, suffered with it for 26 years. Since I come to HMP X are you on about, yeah?...Erm, outside I was sectioned a number of times for the safety of myself and other people because of my tendency to attack other people, innocent people mainly. Erm…since being in custody, I have received a lot more treatment than I did on the outside, erm, the trust you know, erm, with the mental health team in general, treatment has been assessed properly, outside I was just getting duped in to sedate me... the ones* (assessments) *I had done outside were usually done in one session. You and (cons clinical psychologist) have done 4 or 5 interviews, which to me when I read the report, and I read it very recently just to refresh my memory to see if there was anything addressed that was wrong, I could see no faults in it.*

The collaborative approach used by the FAF allowed him to take part in the assessment more fully than in the past. His history of violence did not interfere with

his assessment, as noted previously the FAF is a consistent but flexible approach to assessment. Service user 3 is more socially included in his current environment than in the past, allowing him to access interventions to meet his needs.

Service user 4, who found some difficulties in expressing herself verbally at times, did feel that the assessment was a joint enterprise of discovery.

Interviewer Did you fell that you were given the opportunity to contribute to the assessment we did as a sort of an equal partner? We tried to find out together what your needs were?

SU 4 *Yeah, found out together, yeah.*

Service user 4 has exhibited challenging behaviours in the past and is adept at pushing people away. Her history of substance misuse, offending behaviours, sexual and physical abuse by her family and partners along with periods of self-harm have all contributed to her social exclusion through labels such as 'difficult' and 'PD'. Being given the opportunity to discuss these issues in a safe and supportive manner in the context of a FAF assessment has empowered her to start the move forward to a more positive life.

Focus Group/ Pre-study Interview:

This focus group, which took place in a high secure prison with a group of life sentenced offenders with mental health problems, was clearly motivated to inform this research project. The issues that the participants wished to discuss were considered at length and they used their experiences of assessment, good and bad, to inform that discussion. Unfortunately, this discussion was not audio recorded due to security issues on the day, but contemporaneous notes were taken which recorded the themes of the discussions.

They felt that the FAF allowed a more comprehensive assessment that does not just focus on the 'event', but allows the development of the circumstances around the 'event' to be more thoroughly assessed. When asked about how they feel generally about assessment, a discussion progressed about psychological assessment, later clarified as psychometric testing. The group felt that the psychologists' assessments left them feeling untrustworthy and paranoid, as the questions were repeated '*to catch them out*'. In a more collaborative assessment, such as the FAF, they felt that

they can clarify the point and express themselves. They did feel that recommendations can sometimes be difficult to implement due to difficulties accessing courses in the prison environment. The group felt that a question should be added to every initial assessment: 'what do you feel your needs are?'

The attendees of this group felt that they were given an opportunity to influence the way mental health assessments are completed with prison based mental health service users. Their connection with this external research study did encourage an interest in taking part in further research. That they were included in setting some of the themes for the study and identifying several areas of development did increase their feeling of social inclusion in a wider society that they will not be directly a part of for some time.

This pre-study interview should have been the second community based focus group which continued as a 1:1 interview due to a high dropout rate. It was with a service user who had one episode of serious offending and had been in prison and hospital settings before progressing back into the community. The high dropout rate was due to several community and inpatient service users not attending the group.

The service user that did attend felt that the level of support through the system was patchy, particularly in the prison and this impacted upon his mental health. Although appreciating support from different professionals, he felt that he lacked confidence with some professionals and this could impact on his discussions about risk and his offence.

Interviewer	...So what sort of things do you think I should be asking them about assessment? What sort of things do you think are important to bear in mind when you are assessing someone who may be in quite a distressed state?
SU PSI	*Erm…well…I do think its er it's probably a focus on, because as your coming through you start off very low and you start getting better and better and better you have different needs as you're getting better and better, and different things are getting assessed. But I think it's always important that you're connected to a level of support that you are offering through that assessment at those stages as well.*

This service user informed several of the general questions used in this study and was empowered by being involved in the research process. His integration back into society continued on a positive trajectory. His social inclusion was enhanced by attending further education which he achieved as a result of increased confidence

and self-esteem. The college of further education he attended was one of the social worlds involved by the FAFs ability as a boundary object to construct bridges to encourage a flow of information that dissipated their misgivings over his serious offence history.

8.2.2 Summary Service Users perspective

Male prison service users felt that the FAF allowed them to collaborate more fully whilst the female prison service users saw the assessment as a way they could discover a way forward. However, being seen on their own wing was seen as a positive element by male and female prison service users. The level of support offered throughout the process was also seen as important. Being seen as an equal partner impacted upon service user confidence which can aid the assessment process. The prison based focus group felt on this question that the FAF did not just focus on their offences but looked at gathering information on the context and experiences that led to the offence. They compared this to their experience of psychometric testing in the prison system which they found an impersonal and negative experience. The pre-study interviewee was adamant in his belief that by supporting service users through the assessment process in a collaborative manner, discussions about risk and offences can be better understood as his confidence and trust increased.

8.2.3 Referrers Perspective:

The referrers were united in the concerns they have with risk. Some felt that the threshold for referring to forensic service was lowering; others felt that substance use was misinterpreted as being solely responsible for the risks associated with her client group. Another referrer questioned the service users' ability to comprehend their own risks which, in her opinion, negated their ability to collaborate in assessment.

Referrer 2 felt that the service user she referred had experienced assessments where she had not been listened to or developed an understanding of her experiences.

Interviewer Did you feel that the service user was supported through the assessment process?

Referrer 2 *Absolutely, and she even said that herself, that she was finding fault from others not listening to her and taking into account everything that had gone on in the past.*

Her experience was that the service user was supported and listened to through the FAF assessment.

Referrer 3 sees a change in the way risk is perceived by adult mental health services who may ask for forensic assessments for lower risks than in the past. He feels that the forensic assessments allow a better management plan to be formulated to reduce the level of risk, increasing the likelihood of a referral and the service user gaining a 'forensic' label which can increase social exclusion. He also talks about substance misuse and personality disorder as being more likely to encourage a referral to the forensic service.

Interviewer I wonder if you could tell me a little bit about your experience of mental health assessments...

Referrer 3 *...and I think it's also fair to say, erm, there's a lot more concern about covering ones back than there used to be, and I think the threshold for referring for forensic assessments are lower than they used to be. I acknowledge now people who, potentially, I wouldn't of referred a couple of years ago. I think that has a lot to do with concerns about risks and managing people in the community...The majority of them not only have a serious mental illness, but have associated problems, either alcohol or substance misuse or both together. Plus the difficulty of personality, often, plus possibly an offending background as well.*

That the threshold for this group of service users being referred to the forensic service for assessment is reducing and is being linked to substance use and personality disorder will further increase the social exclusion of this group of service users.

Referrer 4 has a general opinion that service users can sometimes have difficulties in understanding the nature of their risks to others and that this can impact on their ability to collaborate in an assessment.

Interviewer What about with other assessments, do you think there is an aspect of being an equal partner?

Referrer 4 *No, again, I think it's very difficult with the clients I've got and, erm, the majority of them don't accept that they have symptomatology, don't accept that they need medication, and don't accept that they are a risk to other people.*

The issue of insight when in an increased risk or crisis situation requiring a referral to forensic services leaves the social inclusion agenda lower down her list of objectives at the of risk formulation stage.

Referrer 5 felt that her client group, people with drug and alcohol addictions, were judged by most services as having risks that were directly related to their substance misuse. She found the FAF assessment did not do that and gave a clear risk assessment. She appreciated support with a particular service user who had a history of serious violent offences.

Interviewer Do you think that your clients' can contribute to the assessment process as an equal partner with other services?

Referrer 5 *Erm...without a doubt, and I think, often...often they are not given that opportunity... Our clients have very low self-esteem and confidence, er, and often feel their opinion, because of how they have been treated over the years, discriminated against because of substance misuse...And, I think because of the open and honest procedure throughout the assessment that is why he did share that document with probation. So he, because of how the assessment was conducted, it helped him in terms of promoting his autonomy and self-esteem and confidence, which was very low.*

The feeling that this service user had been discriminated against by mental health services because of his substance misuse in the past has been balanced by the FAF approach which was seen to promote autonomy, self-esteem and confidence. This service user consolidated his gains and moved forward with his social inclusion by engaging with specialist personality disorder services following the FAF assessment and formulation.

Referrer 6 appreciated the assessment and advice offered for a service user with risks around sexual offending, a major cause of social exclusion.

Interviewer Were there any differences to other types of assessments, and, if so, what were they?

Referrer 6 *... It was clearly acknowledged that there was a forensic history there; and there were also areas of risk which were different, with the exception of one or two of my clients. The risks were of a sexual nature, er...which were difficult to idolise, (*sic*)... er, categorise over the long term because the risks were always going to be prevalent. And, obviously, we felt the referral under the circumstances, under the past offending behaviour, was essential from our team, we felt that referral was necessary for involvement from the forensic community mental health team.*

The issues around offences of a sexual nature can result in social exclusion on different levels. It may be that interventions or services such as housing are withheld due to the offences committed and associated perceived risks.

8.2.4 Summary Referrers Perspective

Collaboration throughout services was seen as important and a general feeling was that the FAF allowed a comprehensive assessment of risk leading to a better management plan. It was also seen as useful in assessing service users with issues such as firesetting, stalking or sex offending. That referrers concentrate on issues around risk, substance use, offending and sexual risks will contribute to the social exclusion experienced by service users who are assessed by the forensic service. The issues around the service users' experiences and mental health are seen as secondary issues by these referrers. The elements that could add to service user social exclusion include the wish of community referrers to *cover their back, focus on risk and apply further labels* to the service user. The ability of the FAF process to act as a boundary object between different social worlds, encouraging the exchange of information and providing a context to past behaviours to inform a formulated intervention plan that is aware of risk issues can empower referring teams to engage with other social worlds, such as education, employment and housing, that can have a positive effect on social integration.

8.2.5 Assessors Perspective:

The assessing clinicians achieve consensus in that they generally all see assessing risk as the main issue in forensic assessment. The members of the Forensic CMHT felt that risk is assessed better when using a collaborative and holistic approach, such as the FAF. They felt that service users are empowered to cope better by going through this collaborative form of assessment, improving social inclusion in the long term.

Assessor 1, the team psychologist felt that a lot of referrals are concerned purely with risk and that to fully understand risk the service user needs to be fully involved in the process. The FAF helps to achieve the objective of collaboration in forensic risk assessment.

Interviewer Moving on from collaboration and looking at, erm, another word, which is holistic, did you find that the service users you have assessed are seen as individuals, taking into account all their experiences, not just focusing on events?

Assessor 1 *My gut response to that is… not always are they seen in that rounded way. If you were to ask for me to provide you with examples of why I feel that way it would be really difficult for me to be specific about that. I do sense quite often when we are asked to assess patients, or whatever, it is just with that focus on 'there is the risk, how do we manage it, we're finding it difficult to manage it?' or 'Can you tell us how to take it away or deal with that?' I think that sometimes that loses sight of the person as a whole and how they interact and who they are and what's best for them, in a way, so…*

The FAF assessment works towards seeing service users' in a holistic manner which allows people to keep sight of them as an individual, which can be empowering. That this is not always achieved as the focus remains on risk can have an impact on social inclusion.

Assessor 2, the team social worker also felt that risk assessment and management is the *bread and butter* of the teams work, but that the team's way of working, using the FAF, and involving the service user in an open and inclusive way in the assessment process, can uncover issues not previously considered.

Interviewer Looking at outcomes, did you feel that the outcome of the assessment met the needs of the service user? Or that outcomes of assessments meet the needs of service users, you can think of one particular assessment if you like; or just a general…?

Assessor 2 *I suppose it depends what you mean by needs. Sometimes the needs we identify are not the ones the service user wants us to identify. And we maybe highlight risks or concerns that they haven't recognised, or maybe their team haven't. ...Again, the service users, I'm not sure that they always want it, to see these needs identified, but for some, it's a really useful process, maybe not on the day, but see what comes from it afterwards, the treatment, the possibilities of a better way to manage their risks, 'cos it's about them, if they're not aware of what the issues are. I suppose it's exciting finding out what people are doing with you, not this sort of cloak and dagger what may arise on occasions, where they are not really sure what the professionals agenda is and what they are trying to tell them.*

Avoiding the cloak and dagger approach of keeping service users out of the loop can be demeaning and will not enhance social inclusion for them. An inclusive and collaborative approach to assessment, such as the FAF, can avoid this.

Assessor 3, a psychiatrist, felt that supporting the service user is important, as is getting the service users perspective during a forensic assessment.

Interviewer What about the service users perspective on outcomes from the assessment, do you think from their perspective their needs are met?

Assessor 3 *I think, erm, if one of their needs is, and it sometimes it's, for people to sit down and have a chat with them and actually to think about things then I think they would feel that at least that has happened...Generally speaking they are pretty happy.*

That the service user is supported and listened to as part of the FAF process could add to their social inclusion through empowerment and the effect it has on their self-esteem, self-worth and confidence.

Assessor 4, a nurse, feels that prisoners with mental health problems see the assessment as a process as an opportunity for them to improve their lives and to cope better in the prison system.

Interviewer Do you find some of the prison referrals are more forthcoming, more interested in the assessment than people who are referred to the community team?

Assessor 4 *Yeah, I think so...I think here in the prison, the prisoners understand that the mental health (*team input*) isn't towards sentence planning, it's about them as a person, it's not about targets and, er…just not looking at whether they are likely to reoffend, it's their choice to attend at the start of it, to make the best of their lives for however long they are in prison for.*

The independence and choice offered by the FAF assessment, particularly for prison service users, is seen as empowering and could lead to greater social inclusion in the long term.

8.2.6 Summary Assessors Perspective:

The assessors' perspective on the effect of the FAF on social inclusion includes feeling that they are involved and empowered by the collaborative and holistic approach, but that the focus on risk assessment remains and can impact on their future access to services. There is a general consensus between the professionals

that a thorough assessment, such as provided by the FAF can assist with access to social worlds including education, employment, housing and lead to a recovery pathway back into family and social relationships.

8.2.7 Comparator Group Perspective:

Comparator group staff felt that they had other priorities at times including continuing funding for their service and placing more emphasis on public protection. The service user felt that he was treated as an adult.

Service User 6 from the comparator group felt that his self esteem had improved and that he was not treated in a condescending way, but as an adult. He appreciated that he still presented with risks to himself and others, but this impacted positively upon his ability to manage those risks.

Interviewer OK, when you were assessed here with this team, do you feel you were given the opportunity to contribute as an equal partner in the assessment, rather than having it done to you, if you know what I mean?

SU 6 *Yeah, I didn't feel like a student, or something, I felt like a grown up, a person.*

Assessor 5, an occupational therapist from the comparator group, sees assessing and managing risk in terms of accessing ongoing funding for the service she works for, i.e. whether offending rates can be reduced in the people they have assessed and treated.

Interviewer What I would like is both, I would like to hear about your experience of the process now, and how you felt about it in the past.

Assessor 5 *Erm...I think in the past, it was because I was looking for something very specific, it was quite time limited, I was on a ward a lot of the times, so it was very much, an hour, an hour and a half. Our assessment process now is vastly different because, I think it's because of that dual function. What the Department of Health and the Ministry of Justice really want to know is, kind of, facts and figures, I think, a lot about risk and are we worth the money actually that's been spent on us, so, what's our outcomes and what's our evaluation showing and are we doing the job we are paid to do. Erm...from the service user point of view, I guess they're going to think, can you help me get better, can you explain why I am feeling like this.*

Assessor 6, a nurse in the comparator group, discusses the themes of risk and public protection being sometimes higher on the agenda than meeting the needs of the service user.

Interviewer Did you feel that the outcome of the assessment met the needs of the service users?

Assessor 6 *Erm...it's...working in a forensic service, erm, it's an interesting...you're stuck in a little bit of a...erm...there's a dichotomy I suppose, in terms of, you know, who you serve ultimately, and as much as we provide mental health care to patients, erm...and as much as we will look at meeting their needs as much as we can, we also have a public protection, erm...remit, which means that sometimes the outcome of our assessment is about protecting the public, which, sometimes, is at loggerheads with what the patient wants to achieve.*

The dichotomy that this assessor feels as the focus of his service is on risk and puts the safety of the public higher than the needs of the service user which could impact on the service users' level of social inclusion.

8.2.8 Summary, Comparator Group:

The focus of both assessors in the comparator group is not the service user but funders and public protection. How this focus can assist social inclusion remains unclear, but the service user interviewed felt that it was a positive experience and that he was treated as an adult.

8.2.9 Jon's Perspective: Social Inclusion

From my perspective as an auto-ethnographic researcher in this service, I feel that the service users involved in this research process have been empowered by their contributions. The focus group in the high secure prison was seen by the service users who attended as a real opportunity to influence future provision of mental health services and the way assessments are carried out with people who have offended and have mental health problems. They took the group seriously and thought a lot about what they wanted to say and their contribution to the questions asked has impacted considerably on the direction of this study. The service users who were interviewed gave their time willingly and felt that they had a chance to be

listened to and to influence service provision. Some of the interviewees were not in the best of mental health, but insisted on completing the interview they felt so strongly about it. Some of the recollections they made about previous assessments, particularly those that took place some years ago in the prison system, were difficult to listen to at times. They responded positively to being assessed in a collaborative and holistic way, as opposed to being looked at simply as a risk, or someone to be medicated in as little time as possible.

When I met the service user who took part in the pre-study interview, he had just been remanded to prison following the death of his wife, for which he was responsible. He felt that his world had collapsed and that he had no future. During the assessment, when asked about his role, (discursive aspects), he could only see himself as a murderer. He said that he had lost his family, job and social status. He took many months to build trust and complete the assessment process, which he saw as supportive. He felt that the process of being assessed, of being given the opportunity to think about his life, how he felt he fitted into the world and coped with its impact was beginning to change from that moment. Being part of a research project and influencing the themes that would be studied helped him to feel as if he could have a positive impact on the world, and that people may benefit from the experiences he had been through. His suggestions impacted on six of the themes in this study. He went on to retrain following several years of inpatient treatment for his mental health issues and following discharge now runs his own business.

It is clear to me that involving service users in the research process is not only helpful, but that it is essential in providing a different perspective on the area being studied. All health research relates to improving outcomes for service users and their thoughts should be fundamental to health research.

8.3 Summary: Social Inclusion:

In this chapter, the interviews and focus group have been analysed in response to the fourth research question, can a collaborative approach to assessment assist the social inclusion agenda and if so how does involving forensic service users in the research process contribute to this? This is the question that has the least supporting evidence in the qualitative data gathered from the interviews and focus group per se, but many of the issues raised concerning collaboration, a holistic approach, and empowerment in relation to social inclusion have been useful discussions. The input of the service users in the focus group and pre-study interview set some important

themes for the questions asked in the 18 semi-structured interviews. They also felt more involved and included by being asked to contribute to the study at the beginning. As discussed previously, social exclusion can be increased by labels such as *mental health service user, offender, forensic patient* and *substance abuser.* To increase social inclusion, these labels should be challenged as not being abnormal but a part of the human experience that have schemas in the individuals background which can provide insight into their development. In this study, mental health service users are seen to have the possibility of offending or abusing substances as much as the general population. Understanding the reasons for these behaviours is one of the aims of the FAF assessment in an effort to formulate interventions to meet the identified needs that would help to reduce the behaviours. That this can be seen as developing a 'risk management plan' by professionals, i.e. referrers and assessors, but can also be seen as a way to increase social inclusion by empowering service users, is another example of perspectives being dependent on the way reality is perceived, processed and projected by each individual human being.

Service users stated that being assessed using the FAF allowed them to feel more involved in the process and that by collaborating their confidence was improved. They generally saw it as a supportive process and appreciated talking with people outside of their usual environment. This collaboration and support could lead to greater social inclusion, such as attending further education, if confidence and self-esteem were positively affected. The prison based focus group particularly compared their positive experience of being assessed using the FAF to the negative experience of being assessed by psychometric testing prior to attending offence related prison courses such as the Sex-offender Treatment Programme, SOTP.

The referrers to the Forensic CMHT were focused mainly on risk and how it is assessed and managed. There was a feeling that the threshold for making a forensic referral had lowered recently as there is a level of covering their backs. By giving more people a 'forensic' label in this way; social inclusion can be compromised in areas such as access to services. They appreciated the comprehensive nature of the assessment made using the FAF, and liked the management plans they generated, particularly with specialist assessments such as sex offending.

Assessing clinicians from the Forensic CMHT accepted that risk assessment is easily the biggest part of the teams work. They also said that using a collaborative approach, such as the FAF improved the assessments as the service user was more involved in the process. They found that prison based service users were empowered by going through this process, which may impact on social inclusion as they progress through the criminal justice system and back into the community. The comparator group staff felt that they had to prioritise service user needs alongside public protection and funding issues, with service user needs sometimes not being the top priority.

As a boundary object between different social worlds, the FAF does act as a bridge for information to flow. This information not only informs the assessment and formulation process, but flows back to these different social worlds to increase social inclusion. Attending further education or gaining the right type of accommodation can be a vital part of the recovery pathway for service users.

Chapter 9 Discussion

"The creation and management of boundary objects is a key process in developing and maintaining coherence across intersecting social worlds"

(Star and Griesemer 1989 p393)

9.1 Introduction

This chapter will discuss what the main findings resulting from this research project mean to the initial assessment process in forensic psychiatry. It will begin with a synthesis of the knowledge that has been generated and how the conclusions were reached; it will then state what this new knowledge contributes to the knowledge base concerning initial assessment in forensic psychiatry and will then go on to explain what this all means and what new issues and questions have arisen in the course of this research.

At the beginning of this project, I stated that initial assessment in forensic psychiatry could develop into a process that allows the service user, referrer and assessor to develop a better understanding of the service user as an individual and to appreciate their strengths, needs and risks in a collaborative, holistic and inclusive manner. From the initial standpoint of suggesting that an interview schedule could be designed using an approach informed by critical realism to improve initial assessment in forensic psychiatry, the Forensic Assessment Format, (Carey 2006, 2008, Bailey 2012 p161-164), I now suggest that the FAF can act as a boundary object, (Star and Griesemer 1989), between the different social worlds involved with the service user to achieve this collaborative, holistic and inclusive assessment. A theory looking at plural realities will offer an explanation on how people construct their version of events during assessment, *realtà proiettata*.

The insights gained from using the FAF as a boundary object have led to a more collaborative, holistic and inclusive assessment that informs the formulation of a comprehensive set of interventions to meet the needs of the service user, referrer

and assessor. It can also act as a bridge between the different social worlds noted in table 8 reproduced below.

ACCESS LEVEL	GROUP					
MICRO	**Service User**	Prison	Community	Hospital		
	Referrer	Prison	Community	Hospital		
	Assessor	Psychiatrist	Psychologist	Social Worker	Nurse	Occupational Therapist
MESO	**Psychiatric Team**	Forensic CMHT	General CMHT	Prison In-reach	Hospital	
MACRO	**Criminal Justice System**	Police	Probation	Prison	MAPPA	Courts
	Social Support	Family	Carers'	Advocacy		
	Community Services	Housing	Addiction	Employment& Benefits	Social Services	Voluntary agencies
	Education/ University	Research	Supervision	Development	Courses	

Table 8, Conceptual Framework of Social Worlds

The outcomes of this research project can inform the initial assessment process in forensic psychiatry by expanding the multi-disciplinary assessment into an inter-disciplinary assessment process that involves all the micro, meso and macro social worlds in table 8 by the FAF, as a boundary object, acting as an information bridge between these social worlds.

9.2 Synthesis

…no matter how circumscribed or diffuse the initial complaint may be, one knows that the patient is bringing into the treatment situation, whether intentionally or unintentionally, his existence, his whole being-in-his-world. One knows also that every aspect of his being is

related in some way to every other aspect, although the manner in which these aspects are articulated may be by no means clear.

(Laing 1960 p25).

The purpose of this research was to find out how these *'aspects of his being'* are related, to test the hypothesis that initial assessment in forensic psychiatry could be improved by using a more collaborative, holistic and inclusive method. The Forensic Assessment Format, (FAF), (Carey 2006, Carey 2008, Bailey 2012 pp161-164) which is based on an adapted version of the material-discursive-intrapsychic model, (Ussher 2000a) was the basis of the approach as it was developed to be a multi-disciplinary method of initial assessment in forensic psychiatry. As the project progressed it became apparent that the focus was becoming more about the experience of assessment from the perspective of all those involved, i.e. the service user, referrer and assessor as well as the other social worlds involved in the service users' life. That these perspectives often differed led to a discussion about understanding that the plural realities between these different groups could be accepted, shared and understood. Understanding why these different viewpoints of the truth exist and how they interact is a reflective process that can lead to an understanding of the differences and overlaps, as shown in fig.1 reproduced from chapter 1.

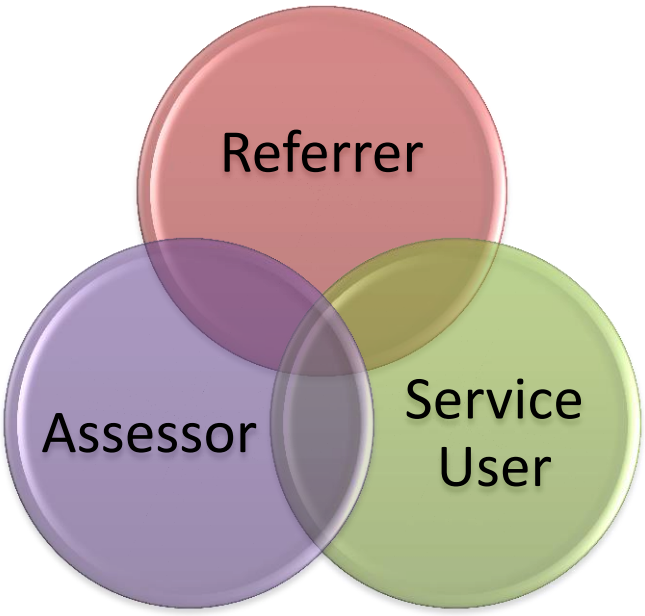

Figure 1 Model of Assessment

Being aware of concepts such as the 'emergent present', (Griffiths, Borkan et al. 2010) and 'futurity from a complexity perspective', (Adam 2005b) have helped in the development of the concept of projected reality (*realtà proiettata*) that is proposed as a method of understanding these plural realities, which I will return to later in this chapter.

Ronald Laing and Thomas Szasz continued an argument about the place of psychiatry and medicine in mental health that has been ongoing since ancient Greece and Rome and probably long before. Arguments about how we perceive and represent the world to others have indeed been put forward by many others since those ancient philosophers, such as Antiphon who offered talking therapy for grief, (Pendrick 2002 pp241, Mann 2005 p47). In *Strategikos,* (The General), Onasander stated that a good general is able to *'cure the souls of their depression'*, (Thayer 1986). Gorgias, who encouraged 'personal coaching', an early form of talking therapy is reported by Sextus to have thought about how people can communicate their perceptions and projections of reality when discussing how to give speeches:

> *Things, on Gorgias's account, cannot be communicated because things are not speeches. I cannot communicate what I see or hear, because I must speak speeches not colours or sounds. We therefore cannot say what is, because what we say exists in a different way from what is. Logos (*Sophists, such as Gorgias, used *Logos* to mean discourse), *is a type of thing alongside the other beings, brought into being by the impression of external things on the speaker. Perceptions cause speeches: a speech that predicates colour is caused by the colour perception, but the speech does not reveal or signify the colour*.
>
> *Sextus Empiricus - Against the Logicians 1.85-86*: (Kochin 2009 pp135)

As we cannot *speak... colours or sounds*, the method offered here, the FAF, looks to reveal the strengths, needs and risks of service users referred for an initial forensic assessment by the use of a *standardised form of boundary object*, (Star and Griesemer 1989). To understand the generative forces underlying our perceptions, a critical realist approach, (Bhaskar 1989) was used for this project as it would seem to be more collaborative, holistic and inclusive in revealing how the different aspects of an individual's essence are articulated.

9.3 Main Findings:

'One of the challenges of moving towards an increasingly interdisciplinary way of working is that involving service users who by the very nature of their complex needs and experiences of using services have encountered practice that has sought to exclude their involvement rather than encourage it.'

(Bailey 2012 p160)

To start the move towards encouraging service users to be more involved in the assessment process, the potential of the new knowledge about initial assessment in forensic psychiatry generated by this project will be explored.

Forensic psychiatry as a clinical specialty developed in the UK in the 1970's and 80's following the *Butler* and *Glancy Reports*, (Home Office and Department of Health 1975), (Department of Health and Social Security 1974) as noted in chapter 2.2.1 above. Forensic psychiatry has a unique place in the psychiatric world as it comes into contact with almost all of the other general and specialist psychiatric services. It also links in with the criminal justice system and community support services as noted in table 8 above. This position enhanced the development of the FAF as a boundary object between these social worlds with information flowing in both directions to assist the service user and referring service to meet their needs.

9.3.1 Research Question 1

Is the clinical impression gained from the initial assessment process in forensic psychiatry improved by employing the professional experience of the assessor and the personal experience of the service user collaboratively through the use of a person centred approach?

All the groups involved in this study agreed that collaboration through the use of the FAF has improved the clinical impression gained from the initial assessment process.

For service users, this means that they are more likely to have their needs met as all the services involved with them have been involved in the process and have ownership of the outcomes. This could be that they achieve more appropriate accommodation as their needs are more accurately assessed, interventions implemented and concerns by other social groups, such as housing, are reduced. The move from service users being passive in an assessment interview to having active involvement is noted as a positive development of the collaborative element of the FAF. For referrers, the improved clinical impression will contextualise events and the expansion of the inter-disciplinary team will help to spread the responsibility for implementing the recommended outcomes of the assessment. For the assessors, knowing that the method of assessment they use does improve the clinical impression by using a more collaborative method increases their confidence in making recommendations based on the FAF. That the FAF teases out why the problematic behaviour occurred, what the thought processes were and not simply recording what happened empowers a more collaborative assessment process. The extra social worlds that are involved in the assessment process help to build networks that can inform the formulation process and they can have more confidence that the outcomes will be implemented.

The FAF acts as a bridge between service users, referrers, assessors and other social worlds as it is a *standardised form of boundary object*, (Star and Griesemer 1989), accessible by all the groups involved. This assessment method where risk and offending issues were not the initial focus, but were gradually approached using the interview schedule of the material section in the FAF, helped to make the initial assessment process less stressful. This more collaborative approach to assessment has provided an opportunity to build trust between the service user and assessing clinician making it easier to develop a positive intervention plan that responds to the needs of the service user. The personal experience of the service user, along with the professional experience of the assessor does improve the clinical impression using this person centred approach.

9.3.2 Research Question 2

How does using an assessment guideline, the Forensic Assessment Format, inform the assessment process to make it more holistic?

The Forensic Assessment Format is seen by all those involved in this study as a holistic method of assessment. For service users, this means that because all their background and development is comprehensively assessed, their needs can be formulated without them being perceived as problems to be solved or symptoms to be treated. This can impact on their self-esteem and can empower them to respond positively to the recommended outcomes. For the referrers, a holistic assessment means that a clear formulation takes place that is informed by all the available information. For the assessors, a holistic assessment process provides an '*excellent framework*' that not only provides clear background and development information, but also information not usually available, provided by the discursive and intrapsychic sections concerning how the service user feels they fit into the world and what its impact is upon them.

The FAF is shown to be holistic in its approach in working to understand the service user, including life trajectories and any history of trauma, as an individual by assessing all of their different aspects and how they are articulated, thereby accepting Laing's advice. This process of holistic assessment is due to the model used, particularly the discursive and intrapsychic elements that look to assess how the service user fits into and is impacted by the world. This holistic approach helps to build trust and a safe environment for the service user to be seen as more than a set of symptoms and risks. It leads to an assessment that informs a fully multidisciplinary approach by the referrers and assessing staff that involves the social worlds accessed by the FAF as a boundary object providing a bridge for information to flow which leads to a more holistic assessment of the service user. Understanding the service users' environment by arranging assessment interviews locally or on their prison wing has the added benefit of easier access to feedback from relatives, carers, pad mates and wing staff.

9.3.3 Research Question 3

What are the processes influencing outcomes for service users when using the Forensic Assessment Format?

The groups involved in this study identified several processes as influencing outcomes. For service users these processes led to them developing increased levels of confidence and empowerment as they felt included as individuals and were listened to and given time to discuss issues, which resulted in developing a therapeutic alliance and having their needs met. For referrers, the processes that meant that they gained support to achieve the recommended interventions included being empowered by a comprehensive assessment report following the FAF assessment as well as ongoing clinical supervision and access to the other social worlds bridged by the *boundary object* effect of the FAF. The assessors felt that the processes influencing outcomes included focussing on the service users' needs by contextualising the events that led to referral. This meant that when using the FAF, they could distance themselves from other influences such as focussing on risk or symptoms and gain information from many social worlds involved with the service user.

The value of developing a therapeutic alliance to contextualise their past has benefits for the service user. These benefits can include putting their life experiences into words for the first time which can be an empowering experience leading to increased self-awareness, esteem and confidence. The power and impact of this on an individual should not be underestimated. That a service user can feel that they have a voice, are supported and will benefit from recommendations being acted upon indicates that there are benefits in terms of outcome from using the FAF.

The outcome of this method of assessment is that the service user has a better chance of being offered interventions or support that is likely to meet their needs. Specialist interventions and further assessments can help with issues such as personality disorder, violence to others, sexual deviance, stalking and fire-setting. By accessing the best outcomes to meet their needs, service users risk levels can be reduced and their protective factors improved. The processes influencing outcomes

for service users when using the FAF include the collaborative and holistic nature of this assessment guideline that impacts positively on the formulation of interventions to meet the service users' needs.

9.3.4 Research Question 4

Can a collaborative approach to assessment assist the social inclusion agenda and if so how does involving forensic service users in the research process contribute to this?

As I noted in the summary of Chapter 8.3, the answer to this question has the least supportive evidence in the qualitative data. In some ways a referral to forensic services can negatively affect social inclusion as service users with a 'forensic' tag can find some difficulty in accessing services and support such as housing. However, the collaborative and holistic process of assessment by the FAF can lead to positive outcomes which, in turn, can help increase social inclusion by, for example, attending further education or voluntary activities. The involvement of service users in setting some of the themes for the interview questions in this study also impacted on involvement and social inclusion.

What do the findings mean for service users in terms of social inclusion? They felt that the FAF assessment process empowered them by increasing their confidence and self-esteem as they were listened to and treated as individuals. They all appreciated being involved in the research process which gave them access to social worlds that they usually do not encounter, such as university researchers. They felt empowered by having an influence on the development of new assessment processes that could benefit them or their peers. For referrers, social inclusion of service users was not high on their agenda. They were focussed on managing risk and 'covering their back'. If anything, they accepted that service users could be negatively affected by a *forensic* referral as it brought in another label to add to *mental health* service user. For assessors, social inclusion was seen to be improved if the assessment could find a positive outcome that met the service users' needs. They felt that the service user was more involved in the FAF assessment process

than other forensic assessments focussed purely on risk, which led to them being empowered to become more socially included through entering new social worlds, such as employment, education or volunteering.

The service users involved in this research felt that they were empowered by being invited to participate and they all displayed a readiness to contribute. They approached the focus groups and interviews seriously, considering their responses in the hope of influencing future service provision; this can be seen as another bridge created by the FAF as a boundary object between service users and the research process. Even when not in the best of mental health, one or two still insisted on taking part and were supported to do so. One of the common themes with service users who had some experience of mental health services was the generally negative responses when asked about previous assessments. Being assessed by staff with no specialist mental health training and being seen as a set of symptoms to be medicated and feeling dismissed as problematic are regular themes that emerge when discussing assessments carried out by some prisons, A&E departments and crisis teams.

It would seem that service users need to be a fundamental part of the research process in forensic mental health from the initial formulation of research questions through methodological choices, data collection, data analysis and dissemination.

9.3.5 Suggestions:

This section concerns the suggestions offered by the participants when asked if they had any thoughts on how to improve the assessment process. The suggestions made by the participants deserve to be discussed and to influence the debate on initial assessment in forensic psychiatry. The focus group and pre-study interviewee also offered several suggestions on improving the assessment process.

The service users would like all psychiatric assessments to be less formal and inquisitional with more time available, such as when using the FAF. There were several suggestions made in the focus group and pre-study interview, including the

importance of being asked for their opinion on what their current needs are during the assessment, getting a copy of the report and an information leaflet prior to assessment. These elements were incorporated into the FAF assessment process. There were several comments from the prison based focus group that psychometric tests, usually self-administered and returned to the assessor on completion, are perceived as impersonal and not holistic, collaborative or individualised when used in isolation. Service users also commented that assessors should have adequate training in assessment techniques, indicating that they feel forensic assessment is an important process that can have an impact on their future progression.

The referrers suggested that the outcome of the assessment should be fed back more quickly. This finding resulted in timescales being introduced to feedback recommendations following assessment. They also suggested that their own documentation could be more evidence based which would make it more useful in measuring outcomes. The forensic CMHT commenced a series of popular training days on risk assessment and management for secondary mental health services within their NHS Trust.

Assessing clinicians suggested that new staff need to achieve some level of competency in assessment prior to completing full assessments. Minimum standards of training for staff using the FAF and subsequent assessment guidelines have been introduced with team members attaining qualifications as trainers in using guidelines including the HCR20^{v3} and SAPROF. They also suggested more involvement of service users and referring staff in completing risk assessments prior to the full forensic assessment, which has been encouraged.

The comparator group felt that the use of time lines, information leaflets, follow up reviews and feedback as well as reviewing their service models would be helpful. This had led to a redesign of some of the documentation for referrers and service users provided by the Forensic CMHT.

These suggestions are summarised in Table 11 below:

SUGGESTIONS	SERVICE USERS	REFERRERS	ASSESSORS	COMPARATOR GROUP
INTERVIEW EXPERIENCE	Less formal			Care coordinator in first interview
ASSESSMENT PROCESS	More time Support from local team	Involve referrers Quicker feedback	More Service User involvement	Time Line
COMMUNICATION		More clinical supervision	Simplify language	Satisfaction Survey
REPORTS	Copy of Report	Meet Prison Service User needs	Improve report writing	
ASSESSOR QUALIFICATIONS	Experienced staff		Improve Assessor Training	

Table 11 Suggestions

Common themes included simplifying the language used; assessing staff liked using the FAF but disliked and struggled with the material-discursive-intrapsychic model, which was shortened to MDI model, and occasionally the *MFI model*, (*MFI* was a chain of furniture stores in the UK). Making the assessment location less formal by not using desks and chairs, but by using sofas or armchairs that would help service users to relax more readily was thought to be a positive step by all groups, (Logan and Johnstone 2013 p266). Taking breaks during a long assessment interview was seen as positive by most as concentration can be compromised after 50-60 minutes. Assessments over several sessions could be less daunting for service users and staff, giving time for clinicians and the service user to consider responses and formulate areas for further discussion.

The five themes arising from this question: Creating an Individualised Interview Experience; Reviewing the Assessment Process; Improving Communication; Report Writing & Dissemination and Assessor Qualifications have led to changes in the process of assessment for the services involved.

The interview experience has been improved by treating the service users and referrers as individuals throughout the assessment process from referral to feedback of recommendations. The option of having familiar staff with the service user during the assessment is now always offered. Keeping the process informal and avoiding

an inquisitional atmosphere is now seen as good practice. Keeping assessing staff trained and updated once they have achieved a level of competency is standard practice. Communication has been streamlined to ensure that all those involved in the assessment process are kept informed. Professional discussions about potential referrals are now commonplace and helpful to all involved. The access to forensic assessment has been improved by using a process that involves a boundary object accessible by the different social worlds involved with the service user. An example would be a local MAPPA chair calling the forensic CMHT with an enquiry about an offender referred to them. This enquiry could then be discussed with the local responsible CMHT to consider if a FAF assessment is indicated with a view to developing a 'bridge' to communicate with others involved in the MAPPA process.

The majority of suggestions made by interviewees concerned their experience of psychiatric assessment generally and they saw the FAF as a good method of assessment when comparing it to other methods of psychiatric assessment, which reflects well on the methods offered by this research project. Accepting and acting upon suggestions, particularly from service users, does assist the social inclusion agenda by encouraging further involvement and engagement from service users particularly, but also from the referrers and assessors involved in the forensic assessment process.

9.4 Strengths and Limitations of the Thesis:

9.4.1 Strengths

One of the main strengths of this study is that the participants involved in it had good levels of experience of the Forensic Assessment Format with 9 of the service users who took part in this study having direct experience of being assessed using the FAF sometime before their participation, giving time for an opinion on its efficacy to develop. The 6 referrers in this study had experience of making several referrals for assessment using the FAF and 4 of the assessors involved had used the FAF since its inception.

The sample in this study reflected the database well with the service user sample being a good match as far as gender and mental disorder were concerned. The referrers were from two different prisons and four different community teams around the Trust where the research took place giving an even spread of experience. The assessors were from four different professional backgrounds, giving a wide viewpoint on the efficacy of the FAF.

The semi-structured interviews produced over 60,000 words of data that were analysed using deductive and abductive approaches which involved returning several times to the data.

The auto-ethnographic approach of the author allowed a full immersion into the service at the heart of this study. This included discussions with individuals in all the social worlds involved in the development of several assessments leading to the formulation of outcomes in the cooperative manner envisaged by Leigh Star, (Star 2010 p604). Her thoughts that cooperation can continue even when consensus is problematic through the use of a boundary object, such as the FAF, meets one of the main needs identified when working with people who are perceived as a risk to others, maintaining open lines of communication.

9.4.2 Limitations:

The main limitation of this study is the lack of valid statistical outcome measures to analyse as the database did not record readmission or reoffending rates for those assessed using the FAF and this information was not available to the author. The benefits and efficacy of the outcomes of the FAF assessment process were assessed by asking the service users, referrers and assessors involved for their opinions, which provided a collection of qualitative data rich in detail. This indicated that the FAF is collaborative and holistic in its approach and that its outcomes meet the identified needs of the service user and referring service.

There was no ethnically diverse element to the samples in this study, which took place in one NHS Trust area. It was not possible to recruit other sites into the study as the FAF was only being used by the Trust in the study at that time.

9.5 Implications for Clinical Practice

"Don't become a mere recorder of facts, but try to penetrate the mystery of their origin."

Ivan Pavlov (1849-1936)

The famous advice offered by Pavlov from the perspective of a physiologist is pertinent to this study and implicit in forensic assessment. How can we penetrate the mystery of an individual's origin whilst not merely recording facts? What has this study told us about initial assessment in forensic psychiatry that we did not know before?

Presented here are the two areas that have emerged from this study and the practical implication that they can have on initial assessment in forensic psychiatry.

9.5.1 The FAF has the Potential to be an Effective Assessment Guideline

The findings from this study support the hypothesis that the FAF works well as a collaborative and holistic assessment guideline that impacts positively on outcomes and social inclusion for service users. It does this by using Jane Ussher's material-discursive-intrapsychic model from a critical realist perspective, (Ussher 2000a), and adapting it into an assessment format that acts as a standardized form of boundary object, (Star and Griesemer 1989 p411).

Assessment is seen as a therapeutic activity by some service users in this study, it was also felt by service users that assessment can be a supportive process. The process of comprehensive initial assessment, such as that undertaken utilising the FAF, may be the first time an individual has considered and discussed their life story

in detail. This life story will bring along with it the emotional reactions that they have experienced in response to those events. The gaining of insight from this process can be cathartic, allowing buried emotions to be expressed. Some assessments completed over many months in institutional or community settings can result in the service user feeling increased levels of self-awareness, confidence and esteem. The danger of triggering a negative response in these circumstances requires skilled and well trained professionals carrying out the assessments; an interdisciplinary approach, particularly in non-health settings such as the criminal justice system; and good quality formal clinical supervision.

One of the potential negative aspects of any therapeutic intervention that improves the social skills of a mentally disordered offender may be that they become better offenders. A shy or timid sex offender, for example, who has previously concentrated on illegal images of a sexual nature, may move towards physical offending with improved confidence and social skills. The use of assessment methods that identify these risks and the processes that protect the service user from reoffending will remain a part of their ongoing risk management plan.

The theme of time developed from the service users and assessors responses, in that having the luxury of time to develop trust and understanding was appreciated by these two groups in contextualising events. The service users interviewed in this study were all appreciative of the time given to build up trust with the assessors. My experience of more than 25 years in forensic psychiatry confirms that this element of not being rushed, having the time to develop themes that emerge from discussions with the service user remains a luxury in specialist psychiatric services when compared to adult mental health services, with their higher caseloads. Having the luxury of having enough time to clarify issues with service users leads to a better understand of both them and their perspectives. Being able to spend time discussing issues important to the service user that may not otherwise be discussed informs the overall assessment and contributes to the contextualisation of events.

After the assessment, the referrers appreciate the time taken to offer feedback to the referring team, the time taken to inform any formulations and the time to attend at a later date to review the outcome. The delays that sometimes occur in completing the

report are not appreciated by referrers and interim feedback after assessment is regularly requested. This could be provided by a discussion directly after the assessment, if possible; by a phone call in the days after assessment or by attending the next weekly review to offer initial feedback.

A detailed report from the assessment helps to inform the formulation process leading to the correct interventions and risk management strategies being implemented by the care team. Having a considered approach such as the material section that takes the background and development into account is important as far as contextualizing events and helps to build up to the risk and offending sections. Assessing how the service user fits into and is impacted by the world using the discursive and intrapsychic sections of the FAF was felt to be an important difference compared to standard assessments.

Service users appreciated being asked to check the report for accuracy prior to signing off and most accepted a copy of the report. Some service users in prisons preferred this copy to go to their legal team or relatives for safekeeping due to the environmental they were incarcerated in. The service users also appreciated follow up reviews that could monitor that any recommended interventions from the report were being implemented.

Training for people who assess service users is vital and not something that develops independently without formal training and supervision. In a forensic service, initial assessments should be observed and supervised prior to staff being seen as qualified to complete independent assessments. Staff in A&E should be supported by mental health training and not just rely on liaison psychiatry services. An attitude of mental health awareness training for A&E staff should be as prevalent as infection control training is for mental health staff, i.e. part of their annual statutory training programme. Prison reception staff will have some experience of using mental health screening tools, such as the *Grubin Tool*, (Grubin, Carson et al. 2002). They should access training on mental health awareness prior to using any screening tool.

Involving service user facilitators such as the now liquidated service user led organisation *emergence*, (1 below), in the education of professionals has been

shown to be effective in the training around personality disorder when delivering the Knowledge and Understanding Framework, (KUF) training, which has been delivered since 2009 in the UK, (2 below). This training is facilitated by two people, one who is a service user qualified by experience and the other who has a professional qualification.

1. http://www.emergenceplus.org.uk/kuf.html
2. http://www.personalitydisorder.org.uk/training/kuf/

The process of initial assessment using the Forensic Assessment Format has been shown to have many benefits to all the social groups involved, particularly on the micro level that includes the service user, referrer and assessor. The checks and balances that occur on the meso level with collaborative working on the assessment within the assessing team and referring service ensure that it is not just the opinion of one professional that informs the outcomes. The involvement of the macro level of social worlds included by the information bridges created by the FAF as a standardized form of boundary object have been shown to enhance the assessment and provide information to facilitate outcomes with the wider inter-disciplinary team.

9.5.2 Projected reality (*Realtà Proiettata*)

The way that the Forensic Assessment Format gathers a collaborative and holistic view of the service user by taking into account all of their background and development, their interactions with the world and its impact on them has led to the concept of projected reality (*realtà proiettata*) being developed to inform outcomes. This concept seeks to explain how an individual uses their experiences, influences, characteristics, nuances and beliefs to process their perceptions of the world and project that as their experience of reality. This projected reality is in a constant state of flux as the individual rides the wave of their own *emergent present, (Griffiths, Borkan et al. 2010)*. This does complicate the assessment process as you can only assess an individual's reality in the moment of that assessment and it is likely to subtly change as the individual continues their journey as an *emergent complex system.* Understanding that individuals are in a state of flux by using this concept of

a projected reality (*realtà proiettata*) allows issues around truth to be contextualised and understood leading to a more holistic assessment.

Projected reality (*Realtà proiettata*) is suggested as a way to understand and explain plural realities in that events can be *perceived* differently and then *processed* by individuals and that each of the resulting *projections* of reality can be equally valid.

Using the material-discursive-intrapsychic model, this processing can be better understood and the generative forces underlying it can be identified to inform the assessment outcomes. Understanding the impact on the service user of their Social, Health and Institutional factors, (material aspects), as well as their self image and interactions with the world, (discursive factors), along with the impact of stress, defence mechanisms and self-esteem and self-worth, (intrapsychic factors), we can begin to empathise with and understand the service users projected reality. The findings of this study include service users feeling safe, having a voice, being treated as an individual and respected, (Chapter 5); not being seen as symptoms or risks but having all their aspects considered, (chapter 6); having events in their lives contextualised, their needs met and developing increased confidence and empowerment, (chapter 7), during the process of assessment using the Forensic Assessment Format.

This concept of projected reality is not just the arena of the service user, but also that of the referrer and the assessor, and indeed all human beings. If the referrers and assessors also understand how their own experiences, influences, characteristics, nuances and beliefs inform their reality, they can be better placed to understand how this can impact on the assessment process, leading to a more collaborative and holistic assessment process. This *perceive-process-project* model of understanding reality needs to be incorporated into the assessment process.

The FAF has been shown to encourage a collaborative and holistic assessment by giving the service user an opportunity to present their projected reality (*realtà proiettata*). The Italian word, proiettata can mean ‘to see clearly’ as well as ‘to be projected’. In Mozart’s opera, The Marriage of Figaro, the word *progetto* is used by Figaro in Act 1 Scene 2 to indicate that he can see clearly:

Bravo, signor padrone! Ora incomincio	*Bravo, my lord! Now I begin*
A capir il mistero...	*to understand the mystery...*
e a veder schietto	*and to see*
tutto il vostro progetto:	*all of your plan clearly:*
a Londra, è vero?	*so, we're going to London?*

(Mozart and Da Ponte 1786)

So, to understand an individual's reality we need to change it from something that they perceive to something that they project, their reality then includes all of the experiences, influences, characteristics, nuances and beliefs that contribute to making them who they are. Seeing individuals as *emergent complex systems* in their own *emergent present,* (Griffiths, Borkan et al. 2010) allows for a more collaborative and holistic assessment, such as that provided by the FAF, to take place. This projected reality or *realtà proiettata* is best understood by seeing the individual inside a *psychological sphere*, the inside of which is their 360^{o} screen used to project their version of reality, past and present. These psychological spheres can then connect with others, and overlap on the parts that are shared or agreed. The FAF approach, using a critical realist standpoint, allows the underlying forces to become apparent by giving the service user the opportunity to share the inside of this psychological sphere to understand their *realtà proiettata*.

9.6 Political Implications of this Study:

The political implications of this study are as important as focussing on the practicalities of implementing the FAF as a boundary object:

> *What we see in this examination of the capacity of a boundary object is two-fold: both practical and political. Practical because it must establish a shared syntax or a shared means for representing and specifying differences and dependencies at the boundary. Political because it must facilitate a process of transforming current knowledge (knowledge that is localized, embedded, and invested in practice) so that new knowledge can be created to resolve the negative consequences identified. This practical and political capacity of a boundary object at a pragmatic boundary provides*

> *an infrastructure or process where current and more novel forms of knowledge can be jointly transformed, producing more shared knowledge or syntax at the boundary.*
> (Carlile 2002 p453)

Transforming current knowledge will impact on both assessment and outcomes when using the FAF, which will continue to develop as an assessment guideline informed by the different social worlds that encounter it. The social worlds it encounters will also develop as a result of the knowledge exchanged across the boundaries inhabited by the FAF as a standardised form of boundary object. These social worlds are inhabited by people who are also *'members in fact of many communities of practice, with varying levels of commitment and consequence'*, (Bowker and Star 1999 p298). The process of forensic assessment should have the characteristic of providing a '*means of resolving the consequences that arise when different kinds of knowledge are dependent on each other'*, (Carlile 2002 p443). These *different kinds of knowledge* may emanate, for example, from the criminal justice system, housing, social services or families and carers who each have their own agenda that does not necessarily reflect the needs of the service user but can contribute valuable information to the assessment process and benefit formulation of outcomes. As discussed in chapter 3.4 above, power relations between service users and professionals in forensic psychiatry have concerned achieving dominance and control to minimise risk to others. Moving towards a more cooperative model of care that seeks to achieve consensus by utilising the boundary object method challenges preconceived political notions of managing risk. This could impact on other social worlds outside of forensic psychiatry, such as those identified in table 8 above. The benefits of having access to a boundary object such as the FAF will be balanced by the responsibilities concerning confidentiality, collaboration, cooperation and implementing recommended outcomes. This could impact on the power balance in social worlds, such as the National Probation Service, who are required to '*deliver the sentences of the court, protect the public and reduce re-offending'*, (National Probation Service 2016 p13). It is recommended in this NPS Operating Model that these objectives are achieved through developing effective partnerships with other partners and having access to the communication bridges provided by the FAF would fall in that category.

As inquiry reports, e.g. *The Clunis Report*, (Ritchie, Dick et al. 1994), found that communication deficits can impact on the care and treatment of service users leading to increased risks developing, the political impact of this study is that it suggests that all agencies involved with service users assessed as having a potential risk to others should use the communication bridges provided by forensic psychiatric services and boundary objects like the FAF to more effectively cooperate and communicate with each other.

9.7 Recommendations for future research

When introducing a new concept, such as Projected Reality (*Realtà proiettata*), the need to discover if this new information contributes to the knowledge base concerning initial assessment in forensic psychiatry, if it is a wise approach in this context, or whether it can help in finding *'the truth'* does need to be further explored. As this concept emerged from an auto-ethnographic perspective whilst engaged in this research project, a further study needs to use a different approach to discover if this is a valid perspective to explain how plural realities could co-exist.

Having had the experience of developing a multidisciplinary assessment guideline, the Forensic CMHT at the heart of this study decided to update its assessment method from the FAF to the Forensic Collaborative Assessment Method, (F-CAM) in 2013. This integrated the *HCR20*, (Douglas and Belfrage 2001) and *SAPROF*, (de Vogel, de Ruiter et al. 2009) assessment guidelines into a collaborative interview schedule informed by elements of the FAF. This balance of a risk assessment guideline, the *HCR20* and a measure of protective factors, the *SAPROF*, looks to assess not only the risk an individual presents but what their protective factors are in reducing or ameliorating that risk.

The development of the F-CAM followed a service development week in 2012 using the Kaizen *continuous improvement* method, (Graban and Swarz 2012). This transformation of the team from the Forensic CMHT into the Forensic Outreach Service, (FOS), was a difficult and at times traumatic experience for the staff, referrers and service user representatives involved in the process. The different

agendas and perspectives that have been highlighted in this study were evident. As well as redefining the service vision, philosophy and protocols, a new assessment method was to be developed. Within the team, a wish to continue with a collaborative and holistic multidisciplinary assessment guideline was challenged by the Forensic Directorates decision to use the HCR20 in all its core assessments. The FAF could not continue in its role as the assessment guideline for the team. However, the experience of using the FAF as a multidisciplinary assessment fed into a decision not to use the HCR20 in isolation. The SAPROF had gained a lot of validity at that time, (de Vries Robbé 2014), and it was decided to incorporate it with the HCR20 and elements of the FAF. One of the team psychologists and the author had been to Utrecht to be trained as trainers for the SAPROF. With input from all involved that week, a proposed guideline emerged, the F-CAM.

Following the Kaizen event, the F-CAM was further developed and refined, replacing the FAF as the Forensic Outreach Service assessment guideline. As I was then on a further period of sick leave lasting several months, this development was led by Dr Lyndsey Nicholson, one of the team psychologists along with other members of the Forensic Outreach Service and was then implemented as the assessment guideline for the FOS in 2013. The F-CAM continued in use for 18-24 months and in that time it became evident that the mental health section was inadequate and needed updating. As the HCR20v^3, (Douglas, Hart et al. 2014), and the SAPROF self appraisal version, (de Vries Robbé and de Vogel 2014) had become available, a decision was made to look at adapting the F-CAM by incorporating these guidelines, formal mental health assessments and elements of the FAF.

The F-CAM was then comprehensively updated in 2015 by the author and Samantha Crawford, higher assistant psychologist, and other members of the FOS into the CHASSIS, the Combined *HCR20^{v3}* and *SAPROF* Structured Interview Schedule, see table 12 below. This assessment guideline incorporated elements of the FAF with the *HCR20^{v3}*, (Douglas, Hart et al. 2014), and *SAPROF* self-assessment, (de Vries Robbé and de Vogel 2014) with the addition of the *Browns Assessment of Beliefs Scale*, BABS, (Eisen, Phillips et al. 1998), *Maastricht Interview*, (Romme and Escher 2000), and the *Autism Spectrum Quotient 10*, AQ10, (Allison, Auyeung et al. 2012) , to inform the mental health section. The interview schedule included the 20 items in

the HCR20v[3] and the 17 items in the SAPROF as well as methods developed in the FAF.

	Detail	HCR20/ SAPROF Items:	Notes
	Guidelines for completion Preamble to interview.		
Part 1:	Family and Social History Relationships Traumatic Experience Employment Forensic Issues Substance Use	H3, H8, R3, S3, S13 H3, S14 H8 H4, S6 H1, H2, H9, C1, C2, C4, S3 H5, R2	Part 1 incorporates *material aspects* from the FAF
Part 2:	Mental Health Maastricht Interview BABS AQ10 Personality Disorder Treatment Supervision Stress/ Coping Instability	H6, H10, C1, C3, C5, R4, S1, S4, S9, S12 H7 H10, C1, C5, R4, S9, S10, S17 R5, S4 C4, S5	Part 2 includes an expanded Mental Health Section that also Incorporates elements of the *discursive/ intrapsychic aspects* of the FAF
Part 3:	Living Situation Leisure & Finance Treatment Plans Additional Information Recap and Conclude *Report Advice* *References*	R2, S16 S7, S8 R1, S11, S15 *NOTE:* *H = Historical 1-10* *C = Clinical 1-5* *R = Risk 1-5* *S = SAPROF 1-17*	Part 3 incorporates elements of the *discursive aspects* from the FAF

Table 12 CHASSIS assessment guideline sections

The authors of the HCR20v[3] and SPAROF were contacted and gave permission for this use of their intellectual property. Indeed, Michiel de Vries Robbe has added further support for using structured assessment methods in risk and protective factors, (de Vries Robbé and Willis 2016).

The experience of developing the FAF allowed the evolution of assessment with this team to progress from the FAF to the F-CAM to the CHASSIS with minimal disturbance to the communication between the Forensic Outreach Service, service users, referrers and the wider inter-disciplinary team as highlighted in the macro

element of table 8 above. The communication bridges created by the FAF as a boundary object transferred smoothly to the F-CAM and CHASSIS. The focus of the report resulting from the CHASSIS assessment is to feed into formulation and scenario planning to inform interventions that aim to meet the needs identified. Service users' remain central to this process by keeping their expectations and hopes in focus.

Has the CHASSIS been an improvement on the FAF and the F-CAM? Has re-introducing more elements of the material-discursive-intrapsychic model into it aided the contextualisation of events as indicated by this study? Has a more detailed assessment been achieved with the CHASSIS by the addition of approaches used in the FAF? Is the CHASSIS a standardised form of boundary object encouraging multi-agency engagement in assessment? Does it focus on service users' expectations and hopes? These are area's that need further development, clarification and study.

Having worked in the medium forensic service in Middlesbrough since 1986 and in the forensic community service since 1994, I have seen the service in Middlesbrough; originally the Hutton Centre and now Ridgeway grow into the largest NHS medium/ low secure forensic service in the UK. I suggest that a study into the efficacy of this service should be commenced. This could be in the form of a longitudinal outcome study that follows up service users discharged from Ridgeway. Initially this could be a retrospective study of those discharged previously through follow up interviews, file reviews, and interrogation of databases to assess areas including readmission and reoffending rates. A regular assessment of service users to assess their progress, as well as reoffending and readmission rates could then be completed every few years. This information could inform service development in the future. A method such as the Hoeven Outcome Monitor, (Keune, De Vogel et al. 2016), which is under development at the Van der Hoeven Clinic in Utrecht has potential to be of use in this enterprise. It is being designed to provide comparative outcome measurements of forensic psychiatric treatment at a macro-, meso-, and micro-level. This could improve decision making methods in risk prediction and

assessment where there is *either little relevant data, or...poorly structured data*, (Constantinou, Freestone et al. 2015 p22).

The trajectory of a service user going through the forensic service for the first time commences with a referral from secondary adult services for an opinion. This referral is considered and if accepted an initial forensic assessment takes place. This assessment may take place in a hospital, within the criminal justice system or in the community. For the service user, this may be the first opportunity they have had to consider their life experiences in detail and to contemplate their emotional responses. Understanding how the service user interacts with the world, experiences it and describes that experience will inform the formulation of interventions to meet the identified needs of the service user. By using a collaborative approach to assessment that allows a holistic picture of the service user to emerge, outcomes should improve allowing the service user to return to secondary and then primary mental health services more quickly, reducing expenditure on expensive tertiary services. At the same time the service user is empowered to engage in less problematic and chaotic lifestyle choices by developing effective coping strategies and using protective factors that prevent him having a raised risk of reoffending or relapsing.

The methods suggested in this thesis support Foucault's challenging of the truth and his search for a reality that is not self-evident, but waiting to be discovered, (Foucault 1967). This concept was further developed by the addition of human activity put forward by Pilgrim and Rogers when discussing social constructivism who stated that '*reality is not self-evident, stable and waiting to be discovered, but instead it is a product of human activity',* (1999 p18). The concept of projected reality that I offer places this challenging of the truth in the arena of critical realism and the search for generative forces. I feel that this supports the idea that mental health should be seen as a social and not a physical science as has previously been espoused by Szasz, (1984) and discussed by Cresswell, (2008).

In Caroline Logan and Lorraine Johnson's book, Managing Clinical Risk, they suggest that:

> *More publications on the topic of forensic clinical interviewing, more research on interviewing techniques, and more practice-developed courses on this particular skill are urgently required.*
>
> (Logan and Johnstone 2013 p317)

I hope that this thesis has made a start in this endeavour by offering an understanding of the perspectives of those involved in the initial assessment process in forensic psychiatry and by making some suggestions on how that process can be more collaborative, holistic and inter-disciplinary. I suggest that by using an assessment guideline such as the FAF, which acts as a boundary object to create information bridges between different social worlds to inform the assessment process, cooperation will be encouraged in achieving formulated outcomes to benefit service users.

Chapter 10 Appendices

10.1 The Forensic Assessment Format

The Guide is definitive. Reality is frequently inaccurate.

(Adams 1995 p178)

Middlesbrough moving forward

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Forensic Assessment Format

The contents of this assessment are confidential and cannot be disclosed without the expressed permission of the author and service user.

Forensic Community Mental Health Team
Cleveland Way
Ridgeway
Roseberry Park
Marton Road
Middlesbrough
TS4 3AF
Tel. 01642 837509 Fax 01642 837688

making a difference together

When stating ethnicity of the service user please use the following codes:

Ethnicity	Code
White – British	A
White – Irish	B
White – Other	C
Mixed – White & Black Caribbean	D
Mixed – White & Black African	E
Mixed – White & Asian	F
Mixed – Other	G
Asian – Indian	H
Asian – Pakistani	J
Asian – Bangladeshi	K
Asian – Other	L
Black – Caribbean	M
Black – African	N
Black – Other	P
Chinese	R
Any other stated ethnic group	S

FORENSIC ASSESSMENT FORMAT CPA 1

Service User Name Date of Birth

Address

Responsible Trust

Date of Assessment

Post Code Home phone no. Mobile Number

NHS Number ID/Hospital Number NI Number

Title Gender Status - Married or Civil Partnership/ Single/ Divorced/

Religion Ethnicity First Language

Communication/Interpretation Service Required? ☐ Yes ☐ No If yes, which service?

Any Previous Names/Preferred Name

Present Address if different from above

Telephone Number

Name and Address of Next of Kin Significant others: include Name & Address

Telephone Number Telephone Number

Relationship Relationship

Carers Details

General Practitioner Address

Telephone Number

Consultant Telephone Number

Social Worker Telephone Number

Community Psychiatric Nurse Telephone Number

Other Telephone Number

Care Co-ordinator Telephone Number
Designation

Care Programme Approach Level Current Diagnosis

Referral Details

Name of Referrer

Date of referral:

Designation/ Organisation

Contact Details/ phone number

Reason for Referral: *(include current mental health issues/ problems and presenting risk factors)*

Sources of Information: *(people interviewed, reports etc.)*

Interview with patient☐	Interview with family☐	CPA meeting ☐
GP Notes ☐	Depositions ☐	Prison Notes ☐
Previous convictions☐	Social Service records ☐	MAPPA/ MARM ☐
Prev Psych Records ☐	Old Psychology notes ☐	Probation ☐

Location of assessment:

Service user's perspective:*(discuss with service user why they feel they have been referred, and/or their current concerns)*

Has an explanation been given on nature and limits of this interview?
(Forensic CMHT will not be taking over care, will make recommendations etc.)
Yes **No**

I agree that the details above are accurate, and that information gained at this assessment can be used in anonymised research projects. I understand that confidentiality will be maintained within the care team.

Service Users Signature……

Assessment of Social, Health and Institutional History
Material Aspects

A. Social Factors:
Family and Social History
Family Tree:

Development: *(childhood, education, socio-cultural/ environmental issues, employment history, daily living skills)*

Relationships: *(with family and friends, include any family psychiatric/ criminal history; marriages/ co-habitation, divorce; children-include current contacts)*

Sexuality/ Gender: *(orientation, activity, significant relationships and why ended, current relationship status, prospects; abuse issues, difficulties)*

Interests/ Hobbies

Bereavement *(experience, unresolved grief etc)*

Spiritual/ cultural issues

Other Information *(received from family, carers, hospital / prison wing staff; Include risk factors, symptoms etc)*

Carers Issues *(note if carers' assessment completed)*

Capacity

Has the service user made an advanced decision?

Has the service user made an advanced request?

Child Protection Issues *(ask about any contact or relationships with children-emotional attachment, school attendance, interventions and behaviour; history of care homes/ social services involvement-self or children, experiences)*

Drug and Alcohol History *(include past and present, timescales, types, quantities, detox history, motivation to change)*

Presentation at Interview *(attitude, demeanour, whether relaxed, open, hostile etc.)*

Finance

Does the service user have any financial problems? If so, describe…

Does the service user have any unmet financial needs?

B. Health factors:

Medical History *(include current and past medication; any history of diabetes, asthma, epilepsy, heart conditions, raised BP, head injuries, loss of consciousness; operations, continence, pressure ulcers, hygiene, A&E etc.)*

Mental State *(current presenting problems, brief synopsis)*

Appetite and Weight *(include eating disorders, body image, nutrition, any recent changes)*

Sleep *(include usual and current sleep pattern, initial insomnia, early morning waking, number of hours)*

C. Institutional Factors:
Forensic History

Current Legal Status: *(Mental Health Act; Remand/ Convicted; subject to public protection)*

Important Dates: *(Court, Care Programme Approach, Multi Agency Public Protection Arrangements Meeting Etc.)*

Current Charge(s) or Index Offence(s):

Details of Current Offence/ Charge

Previous Convictions (*include court disposals and breaches, non-convictions, matters pending, any use of weapons)*

Prison *(current and previous custodial sentences and experiences, bullying, self harm, education etc)*

History of contact with Psychiatric Services

(*First contact, admissions, legal status, compliance, level of security, loss of contact, triggers for deterioration, personal experience.)*

History of deliberate self harm and/ or suicide attempts

Previous Treatments/ Therapies

How the patient interacts with the world
Discursive Aspects

Assess the patient's self-image and interactions with the world.
(Consider how they fit into the world, role development; communication skills, assertiveness, literacy; stigma and gender issues.)

Expectations and Aspirations. *(Assess and note if there is any stress caused by differences)*

Miracle Question:
Suppose, after we finish here today, you go home, do your jobs watch TV, and so on; then go to bed and sleep. While you are asleep, a miracle happens, and the problems we have discussed today are resolved, just like that! This happens when you are asleep, so you don't know how it happened. When you wake up, how will you know that this has happened? What are the signs? What will you be doing that is different?

How the world affects the patient
Intrapsychic Aspects

How does stress impact on the individual?

(*E.g. physical/ emotional responses to stress from factors such as current environment, family, guilt, abuse, exploitation, personal safety etc.)*

What defence mechanism does the individual use?

(E.g. repression, denial, projection, rationalisation, regression, displacement, sublimation, self harm, etc)

What is the individual's self-esteem and self worth?

(E.g. how they describe and feel about themselves)

Psychometric Tests

Brief Psychiatric Rating Scale (BPRS)

Instructions:

This form consists of 24 symptom constructs, each to be rated in a 7-point scale of severity ranging from 'not present' to 'extremely severe'. If a specific symptom is not rated, mark 'NA' (not assessed). Circle the number headed by the term that best describes the patient's present condition.

1	2	3	4	5	6	7
Not present	Very mild	Mild	Moderate	Moderately severe	Severe	Extremely severe

Rate items 1-14 on the basis of patients self-reporting during the interview
Rate items 15-24 on the basis of observed behaviour or speech during the interview

1	Somatic concern	NA	1	2	3	4	5	6	7
2	Anxiety	NA	1	2	3	4	5	6	7
3	Depression	NA	1	2	3	4	5	6	7
4	Suicidality	NA	1	2	3	4	5	6	7
5	Guilt	NA	1	2	3	4	5	6	7
6	Hostility	NA	1	2	3	4	5	6	7
7	Elated Mood	NA	1	2	3	4	5	6	7
8	Grandiosity	NA	1	2	3	4	5	6	7
9	Suspiciousness	NA	1	2	3	4	5	6	7
10	Hallucinations	NA	1	2	3	4	5	6	7
11	Unusual thought content	NA	1	2	3	4	5	6	7
12	Bizarre behaviour	NA	1	2	3	4	5	6	7
13	Self-neglect	NA	1	2	3	4	5	6	7
14	Disorientation	NA	1	2	3	4	5	6	7
15	Conceptual Disorganisation	NA	1	2	3	4	5	6	7
16	Blunted affect	NA	1	2	3	4	5	6	7
17	Emotional withdrawal	NA	1	2	3	4	5	6	7
18	Motor retardation	NA	1	2	3	4	5	6	7
19	Tension	NA	1	2	3	4	5	6	7
20	Uncooperativeness	NA	1	2	3	4	5	6	7
21	Excitement	NA	1	2	3	4	5	6	7
22	Distractibility	NA	1	2	3	4	5	6	7
23	Motor hyperactivity	NA	1	2	3	4	5	6	7
24	Mannerisms and posturing	NA	1	2	3	4	5	6	7

BPRS Score 1…… Date ……

BPRS Score 2 …… Date ……

Tees, Esk and Wear Valleys NHS
NHS Trust

HoNOS-*Secure* (v.2) Score Sheet

Refer to guide when completing, severity is measured on the following five point scale:

0 = no problem
1 = minor problem requiring no action
2 = mild problem but definitely present
3 = moderately severe problem
4 = severe to very severe problem

SECURITY RATING (Historical Assessment)

A	**Rate potential harm to adults or children**	☐
B	**Rate potential self harm**	☐
C	**Rate need for building security to prevent escape**	☐
D	**Rate need for a safely-staffed living environment**	☐
E	**Rate need for escort on leave**	☐
F	**Rate risk to individual from others**	☐
G	**Rate the need for risk management procedures**	☐

Total (0-28) ☐

Scales 1-12 (Rate the past two weeks)

1	**Overactive aggressive disruptive or agitated behaviour**	☐
2	**Non-accidental self-injury**	☐
3	**Problem drinking or drug taking**	☐
4	**Cognitive Problems**	☐
5	**Physical Illness or disability problems**	☐
6	**Problems with hallucinations and delusions**	☐
7	**Problems with depressed mood**	☐
8	**Other mental and behavioural problems**	☐
	(Specify disorder A, B, C, D, E, F, G, H, I or J) ☐	
9	**Problems with relationships**	☐
10	**Problems with activities of daily living**	☐
11	**Problems with living conditions**	☐
12	**Problems with occupation and activities**	☐

Total (0-48) ☐

Risk Assessment

Risk of self-harm: *(consider triggers and history of deliberate self harm; risk of suicide)*

Risk to others: *(consider violence, fire setting and sexual risks; Multi Agency Public Protection Arrangements, child protection, vulnerable adult and carer issues)*

Risk of neglect: *(consider current circumstances, support, carers etc.)*

Risk of exploitation: *(by/ to others)*

Other identified risks/ triggers: *(include any other assessed risk factors, such as psychotic symptoms, highlighted in the assessment, Note current and recent circumstances, and patients concerns for the future)*

Risk Management
Actions / Behaviours likely to increase risk levels:

Actions / Behaviours likely to decrease risk levels:

SUMMARY

Brief outline of the patient's presentation, utilising all of the sections, and summarising the patient as an individual, highlighting identified needs. Comment on appropriateness of current care plan, including accommodation, social support, medication, professional input, legal status, occupation and compliance.

RECOMMENDED INTERVENTIONS:

Define the interventions suggested by each section of the assessment to meet the patient's needs. Consider accommodation, social support, medication, professional input, risk management, legal status, occupation and compliance. Note successful previous strategies suggest further strategies, with supporting evidence; and note what the Community Forensic Service can offer, such as joint working. Consider referral to Multi Agency Public Protection Panel / child protection/ domestic violence unit etc.

Assessing Professionals

1 **2**

Name:

Signed:

Designation:

Date of assessment: **Review date:**

Contact Number:

This version of the Material-Discursive-Intrapsychic Model of Critical Realism was inspired by the work of Prof. Jane Ussher of the University of Western Sydney, Australia. Adapted by Jon F Carey, and enhanced by the Forensic Community Mental Health Team at The Hutton Centre, St. Luke's Hospital, Middlesbrough.

JFC May 2010
jon.carey@nhs.net

10.2 Research Questions

10.2.1 Research Questions – Service User

Research Questions, Service User:

1. *Introduction:*

   Hello, thanks for coming today. I wonder if you could tell me a little bit about the assessments you have experienced in regards to your mental health, how many you have had and over what period?

   Do you remember being assessed by the Forensic CMHT?

   Did you notice any differences to the other assessments?

   How would you describe your experience of the assessment process?

   With the Forensic CMHT

   With others

2. *Collaboration:*

   How did you find being given the opportunity to contribute to the assessment process as an equal partner?

   With the Forensic CMHT

   With others

3. *Holistic:*

   Was it your experience that you were assessed as an individual taking into account all your experiences, not just focusing on events? 1

   Do you feel that your background and development were taken into account to put events in context? 1

   With the Forensic CMHT

   With others

4. *Outcomes:*

How do you feel that the outcome of the assessment met your needs, and were you given the opportunity to give and receive some feedback to and from the assessors?

With the Forensic CMHT

With others

5. *General:*

   What is your opinion on the length of the assessment interview?

   Did you feel that the assessment interview went into the right amount of detail? 1

   Did you feel supported through the assessment process? 2

   Would you like a choice of where the assessment takes place? 2

   Was your experience that the report reflected your current needs?

   Would you like a member of staff with you at the assessment? 2

   Was your experience that the report accurately reflected you as an individual?

   Did you get or would you like a copy of the assessment report? 1 +2

   Would you like a follow up appointment after 3- 6-12 months? 1 + 2

   Would information given before the assessment to help you prepare? 2

   Do you feel that you should be asked what you feel your needs are? 1

   Have you any suggestions that you feel would improve the assessment process?

1 = Focus Group 1 2 = Interview

10.2.2 Research Questions – Forensic CMHT Staff/ Comparator Group Staff

Research Questions, Assessors:

1. *Introduction:*

   Hello, thanks for coming today. I wonder if you could tell me a little bit about your experience of mental health assessments.

   How would you describe your experience of the assessment process?

   With the Forensic CMHT using the FAF

   With others teams

   What were the differences, if any, to other types of assessments?

2. *Collaboration:*

   Did you find that the service users you have assessed were given the opportunity to contribute to the assessment process as an equal partner?

   With the Forensic CMHT

   With others

3. *Holistic:*

   Did you find that the service users you have assessed are seen as individuals, taking into account all their experiences, not just focusing on events?

   Do you feel that their background and development was taken into account to put events in context? 1

   With the Forensic CMHT

   With others

4. *Outcomes:*

   Did you feel that the outcome of the assessment met the needs of the service user?

   Were you given the opportunity to give and receive some feedback to and from the referrers and the service user?

   With the Forensic CMHT

   With others

5. *General:*

   What is your opinion on the length of the assessment interview?

   What is your opinion on the amount of detail the assessment interview goes into? 1

   Did you feel the service user was supported through the assessment process? 2

   Do you feel the service user should have a choice of where the assessment takes place? 2

   Was it your experience that the report accurately reflected the current needs of the service user you assessed?

   Do you feel that the service user should have the option of having a member of the local staff with them at the assessment? 2

   Did you feel that the report accurately reflected the service user you assessed as an individual?

   Should the service user get a copy of the assessment report? 1 + 2

   Would you like to do a follow up appointment after 3- 6-12 months with the service user and/or referrer? 1 + 2

   Should the service user have more detailed information, prior to the assessment, of the process involved? 2

   Do you feel that the service user should be asked what they feel their needs are? 1

   Have you any suggestions that you feel would improve the assessment process?

   1 = Focus Group 1 2 = Interview

10.2.3 Research Questions – Referrers

Research Questions, referrers:

1. *Introduction:*

   Hello, thanks for coming today. I wonder if you could tell me a little bit about your experience of mental health assessments.

   Do you remember referring to the Forensic CMHT?

   Approximately how many referrals have you made in the last 12 months to the Forensic CMHT?

   Were there any differences to other types of assessments, and, if so, what were they?

   How would you describe your experience of the assessment process?

   With the Forensic CMHT

   With others

2. *Collaboration:*

   Did you find that the service user(s) you referred was given the opportunity to contribute to the assessment process as an equal partner?

   With the Forensic CMHT

   With others

3. *Holistic:*

   Did you find that the service user you referred was assessed as an individual taking into account all their experiences, not just focusing on events? 1

   Do you feel that their background and development was taken into account to put events in context?

   With the Forensic CMHT

   With others

4. *Outcomes:*

   Did you feel that the outcome of the assessment met the needs of the service user you referred?

Were you given the opportunity to give and receive some feedback to and from the assessors?

With the Forensic CMHT

With others

5. *General:*

What is your opinion on the length of the assessment interview?

What is your opinion on the amount of detail the assessment interview went into? 1

Did you feel that the service user was supported through the assessment process? 2

Do you feel that the service user should have a choice of where the assessment takes place? 2

Was it your experience that the report accurately reflected the current needs of the service user you referred?

Would you be happy to provide a member of staff to sit in with the service user during the assessment? 2

Did you feel that the report accurately reflected the service user you referred as an individual?

Did you give the service user a copy of the assessment report? 1 + 2

Would you like a follow up appointment after 3- 6-12 months? 1 + 2

Would information given to the service user about the assessment prior to the appointment have been helpful? 2

Do you think that the service user should be asked what they feel their needs are? 1

Have you any suggestions that you feel would improve the assessment process for service users or referrers?

1 = Focus Group 1 2 = Interview

10.3 Information Document

Middlesbrough Integrated Mental Health Services
Forensic Community Mental Health Team
Ridgeway
Cleveland Way
Roseberry Park
Middlesbrough
TS4 3AF
Tel: 01642 283384
Fax: 01642 283345

PARTICIPANT INFORMATION SHEET

Project title Initial Assessment in Forensic Psychiatry

Researcher's name Jon F Carey

Supervisor's name Di Bailey

This is a completely voluntary project, and you can withdraw at any time.

You are being invited to take part in a research project looking at the way professionals and service users can work together to make assessment more of a partnership, giving equal weight to the service user and the professionals perspective. It will look at the initial assessment to see if it can be improved by using the Forensic Assessment Format, a tool designed by the researcher.

The project will cover the Tees Valley and Durham area, inviting service users and staff to give their opinions and thoughts on the assessment process used by the Forensic Community Mental Health Team at the Hutton Centre.

Service users will be given the opportunity to set some of the themes for questions to be used in the 18 interviews of this project by attending one of two focus groups. Service users in the Durham prisons will be included. The interviews will take place in your local community health location.

What is required by participants in the project?

- As a participant in the project, you will be required to give your informed consent to being involved, and to sign a Participant Consent Form.

- Those service users participating in a focus group, will be asked to attend the agreed location for approximately 1 hour and take part in a discussion setting themes to inform some of the questions for the semi-structured interviews. You will be someone who has been through an assessment using the Forensic Assessment Format by a member or members of the Forensic Community Mental Health Team at the Tees, Esk & Wear Valleys NHS Trust.
- As a service user or member of NHS & Prison staff selected for interview, you will be asked to attend an agreed location for a period not exceeding 1 hour, of which the interview should last no longer than 30-45 minutes. The interview will be recorded.
- Information from community based assessments is stored on a database at the Tees, Esk & Wear Valleys NHS Trust, and this information will be analysed using computer programmes.

Confidentiality & Security of Information

- All personally identifiable data will be stored securely in a locked cabinet in a locked room at the Tees, Esk & Wear Valleys NHS Trust for the duration of the study, after which it will be securely destroyed.
- Interview data will be transcribed, anonymised, and stored electronically on secure hard drives at Tees, Esk & Wear Valleys NHS Trust and the University of Durham for the duration of the study, after which it will be securely destroyed.
- The researcher, Jon Carey, and his supervisors, Di Bailey and Prof David Byrne at Durham University are the only people with access to the data which will be anonymised prior to analysis. Transcription will be by secretarial staff employed by Tees, Esk & Wear Valleys NHS Trust.
- Any data submitted for publication will be anonymised, and participants will not be identifiable.
- Information gained in this project will be used to achieve the aims set out above.
- <u>All recordings made during this study will be destroyed when the study has been completed.</u>

Participation in the Project

If you have agreed to participate in this research project, your involvement is completely voluntary and you are able to withdraw at any time. This will not affect your rights or access to other services or care.

Potential risks, harms and benefits to participants

As this research project concerns initial assessment, service users may be asked to revisit topics that could be difficult to discuss and which may cause anxiety and/ or distress. Although this is unlikely, you will be given the opportunity to discuss any issues that arise from this with your own care team. Staff will have access to staff support services. It is hoped that the project will make initial assessment a more rounded and thorough collaborative process, meeting all the aims set out above, and that this will benefit both service users and staff.

Contact details

Researcher: Jon Carey: Ridgeway, Cleveland Way, Roseberry Park, Marton Road, Middlesbrough. TS4 3AF

Supervisor: Di Bailey: School of Applied Social Sciences, Durham University, Elvet Riverside 2, Durham.DH1 3JT

In the event of wishing to make a complaint about the way in which this research has been conducted, please contact:

Jacqui Lovell: R & D Manager: Tees, Esk and Wear Valleys NHS Trust, Training and Development Centre, Ormesby Rd, Berwick Hills, Middlesbrough. TS3 7SF

10.4 Consent Form

Middlesbrough Integrated Mental Health Services
Forensic Community Mental Health Team
Hutton Admin Block
St. Luke's Hospital
Marton Road
Middlesbrough
TS4 3AF
Tel: 01642 283384
Fax: 01642 283345

PARTICIPANT CONSENT FORM

Project title Initial Assessment in Forensic Psychiatry
Researcher's name Jon F Carey
Supervisor's name Di Bailey

- I have read the Participant Information Sheet and the nature and purpose of the research project has been explained to me. I understand and agree to take part.
- I understand the purpose of the research project and my involvement in it.
- I understand that I may withdraw from the research project at any stage and that this will not affect my status now or in the future.
- I understand that while information gained during the study may be published, I will not be identified individually, and my personal details will remain confidential.
- I understand that the interview will be recorded to maintain accuracy.
- I understand that paper copies of the data will be stored for the duration of the study in a locked cupboard in NHS premises. Anonymised electronic data will only be stored on secure hard drives at Durham University and at Tees, Esk & Wear Valleys NHS Trust. Access to this data will be by Jon Carey and his supervisor only. At the end of this research project, the data will be confidentially destroyed.
- I understand that I may contact the researcher or supervisor if I require further information about the research, and that I may contact the Research & Development manager at Tees, Esk & Wear Valleys NHS Trust, if I wish to make a complaint or representation relating to my involvement in the research.

Signed …… (research participant)

Print name …… **Date** ……

Researcher:
Jon Carey:
Ridgeway
Cleveland Way
Roseberry Park,
Marton Road,
Middlesbrough TS4 3AF

Supervisor:
Di Bailey:
School of Applied Social Sciences,
Durham University,
Elvet Riverside 2,
DurhamDH1 3JT

10.5 Ethical Approvals

14th September 2007

Tees, Esk and Wear Valleys NHS Trust, Clinical Negligence Scheme for Trusts (CNST) confirmed – Elaine Radford, Claims Manager

30th October 2007

HMP Durham & HMP Low Newton Research Ethics Approval

Angela Taylor, Psychology Lead

16th November 2007

HMP Frankland Research Ethics Approval

Lorraine Fraser (psychology lead)/ Governor Mullen

3rd January 2008

Northern and Yorkshire Research Ethics Committee Approval

REC reference number: 07/H0903/67

8th January 2008

Tees, Esk and Wear Valleys NHS Trust, Research Governance Approval

Jennifer M Brock.

4th February 2008

Durham University Research Ethics Approval

Helen Charnley, Director PGR

10.6 Interviewees and schedule:

1. Referrer	Nurse, HMP Frankland	Dec 2008
2. Referrer	Nurse, HMP Low Newton	Jan 2009
3. Forensic CMHT Staff	Psychologist	Feb 2009
4. Forensic CMHT Staff	Social Worker	Apr 2009
5. Forensic CMHT Staff	Psychiatrist	Apr 2009
6. Service User	Prison/ MI	May 2009
7. Service User	Prison/ PD	May 2009
8. Service User	Prison/ MI	May 2009
9. Service User	Prison/ PD	May 2009
10.Forensic CMHT Staff	CPN	Jun 2009
11. Referrer	Nurse, Stockton	Jun 2009
12. Referrer	Social Worker, Darlington	Jun 2009
13. Referrer	Nurse, Consett	July 2009
14. Referrer	Psychiatrist, Darlington	Apr 2010
15. Comparator Staff	OT- PD Team	Apr 2010
16. Comparator Staff	CPN - MI Team	Apr 2010
17. Comparator (SU)	Community/ PD	Apr 2010
18. Service User	Community/ MI	Nov 2011

Focus Group 1

1. Service User	PD HMP Frankland	May 2008
2. Service User	PD HMP Frankland	May 2008
3. Service User	MI HMP Frankland	May 2008

Pre-study interview

1. Service User	MI Community	Nov 2008

10.7 Glossary/ Abbreviations

AMHP	Approved Mental Health Professional
AQ10	Autism Spectrum Quotient 10
ASD	Autistic Spectrum Disorder
ASPD	Antisocial Personality Disorder
BABS	Browns Assessment of Beliefs Scale
BDI	Becks Depression Inventory
BPD	Borderline Personality Disorder
CAMHS	Child and Adolescent Mental Health Service
CAPP	Comprehensive Assessment of Psychopathic Personality
CAT	Cognitive Analytic Therapy
CHASSIS	Combined HCV20^{v3} and SAPROF Structures Interview Schedule
CBT	Cognitive Behaviour Therapy
Chromis	Violence Reduction Programme (Motivation and Engagement element)
CMHT	Community Mental Health Team
CTO	Community Treatment Order
CTS-2	Conflict Tactics Scale-2nd Edition
DBT	Dialectic Behaviour Therapy
DSM-IV	Diagnostic & Statistical Manual 4th edition
DSPD	Dangerous and Severe Personality Disorder
EMDR	Eye Movement Desensitisation and Reprocessing
ETS	Enhanced Thinking Skills
FAF	Forensic Assessment Format
F-CAM	Forensic Collaborative Assessment Method
HCR-20	Historic – Clinical – Risk (assessment guideline)
IEP	Incentive and earned privilege scheme
IPDE	International Personality Disorder Examination
KUF	Knowledge and Understanding Framework
LD	Learning Disability
LMV	Life Minus Violence
MAPPA	Multi Agency Public Protection Arrangements
MCMI-III	Millon Clinical Multiaxial Inventory-III
MTC	Mobile Team Challenge

NICE	National Institute for Health and Clinical Excellence
NOMS	National Offender Management Service
NTW	Northumbria, Tyneside & Wearside NHS Trust
OASys	Offender Assessment System
P-ASRO	Prison –Addressing Substance Related Offending
PCL-r	Psychopathy Check List (revised)
PCL-sv	Psychopathy Check List – Screening Version
PCT	Primary Care Trust
PEPS	Psycho-education and Problem Solving
RC	Responsible Clinician
RPIW	Rapid Process Improvement Workshop
RSVP	Risk for Sexual Violence Protocol
SAM	Stalking Assessment & Management Guide
SAPROF	Structured Assessment of Protective Factors
SARA	Spousal Assault Risk Assessment Guide
SARN	Structured Assessment of Risk and Need
SCID I	Structured Clinical Interview for DSM-IV, mental illness
SCID II	Structured Clinical Interview for DSM-IV, PD
SIDP	Structured Interview for DSM-III-R Personality
STAI	State-Trait Anxiety Inventory
SVR-20	Sexual Violence Risk *20*
TEWV	Tees, Esk & Wear Valleys NHS Foundation Trust
TREM	Trauma Recovery and Empowerment Model
VRS	Violence Risk Scale
WAIS III	Wechsler Adult Intelligence Scale, 3rd Edition
WRAP	Wellness, recovery and action plan
YOI	Young Offender Institution

10.8 Tables: Forensic CMHT Database 2004- 2009

A	Referral	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1st referral	340	84.0	84.0	84.0
	2nd referral	57	14.1	14.1	98.0
	3rd referral	8	2.0	2.0	100.0
	Total	405	100.0	100.0	

Table A: Number of times referred

B	Gender	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	male	335	82.7	82.7	82.7
	female	70	17.3	17.3	100.0
	Total	405	100.0	100.0	

Table B: Gender

C	Ethnicity	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	White British	386	95.3	95.3	95.3
	White - Irish	1	.2	.2	95.6
	White - Other	3	.7	.7	96.3
	Mixed - White & Black Caribbean	3	.7	.7	97.0
	Mixed – White & Asian	1	.2	.2	97.3
	Asian – Indian	1	.2	.2	97.5
	Asian – Pakistani	4	1.0	1.0	98.5
	Asian – Other	1	.2	.2	98.8
	Black – Caribbean	2	.5	.5	99.3
	Black – African	1	.2	.2	99.5
	Chinese	1	.2	.2	99.8
	Any other stated ethnic group	1	.2	.2	100.0
	Total	405	100.0	100.0	

Table C: Ethnicity

D	Marital status	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Single	261	64.4	64.4	64.4
	Married/ Civil Partnership	34	8.4	8.4	72.8
	Divorced	31	7.7	7.7	80.5
	Cohabiting	15	3.7	3.7	84.2
	Separated	15	3.7	3.7	87.9
	Widowed	3	.7	.7	88.6
	Unknown	46	11.4	11.4	100.0
	Total	405	100.0	100.0	

Table D: Marital Status

E	Clinic	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Durham	32	7.9	7.9	7.9
	Shotley Bridge	23	5.7	5.7	13.6
	Middlesbrough	107	26.4	26.4	40.0
	Darlington	22	5.4	5.4	45.4
	Stockton	65	16.0	16.0	61.5
	Hartlepool	46	11.4	11.4	72.8
	Redcar & Cleveland	61	15.1	15.1	87.9
	Tyne & Wear	6	1.5	1.5	89.4
	North Yorks.	1	.2	.2	89.6
	Unknown	42	10.4	10.4	100.0
	Total	405	100.0	100.0	

Table E: Referral Area

F	Diagnosis	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Schizophrenia & Other Psychosis	119	29.4	31.7	31.7
	Personality Disorder	86	21.2	22.9	54.7
	Depression	28	6.9	7.5	62.1
	PTSD	3	.7	.8	62.9
	Dementia	4	1.0	1.1	64.0
	Substance Misuse	5	1.2	1.3	65.3
	ADHD	3	.7	.8	66.1
	Adjustment Disorder	1	.2	.3	66.4
	OCD	3	.7	.8	67.2
	Mood Disorder	21	5.2	5.6	72.8
	Learning Disability	6	1.5	1.6	74.4
	Aspergers Syndrome	1	.2	.3	74.7
	Other	7	1.7	1.9	76.5
	Unknown	88	21.7	23.5	100.0
	Total	375	92.6	100.0	
Missing	System	30	7.4		
Total		405	100.0		

Table F: Diagnosis at referral

G	N	Minimum	Maximum	Mean	Std. Deviation
Age	354	17	89	35.72	13.002
Valid N (listwise)	354				

Table G: Age range

H	Living where?	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Hospital	129	31.9	31.9	31.9
	Home	197	48.6	48.6	80.5
	Prison	29	7.2	7.2	87.7
	Residential Home/ Nursing Home/ Supported Accommodation	5	1.2	1.2	88.9
	Unknown	45	11.1	11.1	100.0
	Total	405	100.0	100.0	

Table H: Where living at referral

I	Risk at referral	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Violence	279	68.9	68.9	68.9
	Fire-setting	11	2.7	2.7	71.6
	Sexual	48	11.9	11.9	83.5
	Stalking	6	1.5	1.5	84.9
	Unknown	61	15.1	15.1	100.0
	Total	405	100.0	100.0	

Table I: Main risk at referral

J	Forensic CMHT Diagnosis	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Schizophrenia & Other Psychosis	106	26.2	26.2	26.2
	Personality Disorder	65	16.0	16.0	42.2
	Depression	14	3.5	3.5	45.7
	PTSD	3	.7	.7	46.4
	Dementia	4	1.0	1.0	47.4
	Substance Misuse	6	1.5	1.5	48.9
	ADHD	1	.2	.2	49.1
	OCD	3	.7	.7	49.9
	Mood Disorder	20	4.9	4.9	54.8
	Learning Disability	2	.5	.5	55.3
	Aspergers Syndrome	3	.7	.7	56.0
	Other	9	2.2	2.2	58.3
	Unknown	45	11.1	11.1	69.4
	N/A	101	24.9	24.9	94.3
	None	23	5.7	5.7	100.0
	Total	405	100.0	100.0	

Table J: Forensic CMHT Diagnosis following assessment

K	Criminal record	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	92	22.7	32.1	32.1
	Yes	195	48.1	67.9	100.0
	Total	287	70.9	100.0	
Missing	Unknown	117	28.9		
	System	1	.2		
	Total	118	29.1		
Total		405	100.0		

Table K: Criminal Record

L	Recent "crime"	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	155	38.3	53.6	53.6
	Yes	134	33.1	46.4	100.0
	Total	289	71.4	100.0	
Missing	Unknown	116	28.6		
Total		405	100.0		

Table L: Recent Crime

M	Charges pending	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	230	56.8	81.3	81.3
	Yes	53	13.1	18.7	100.0
	Total	283	69.9	100.0	
Missing	Unknown	122	30.1		
Total		405	100.0		

Table M: Charges Pending

N	Current alcohol abuse	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	186	45.9	68.6	68.6
	Yes	85	21.0	31.4	100.0
	Total	271	66.9	100.0	
Missing	Unknown	134	33.1		
Total		405	100.0		

Table N: Current alcohol abuse

O	Current drug abuse	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	193	47.7	71.5	71.5
	Yes	77	19.0	28.5	100.0
	Total	270	66.7	100.0	
Missing	Unknown	135	33.3		
Total		405	100.0		

Table O: Current drug use

P	Use of weapons	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	175	43.2	63.9	63.9
	Yes	99	24.4	36.1	100.0
	Total	274	67.7	100.0	
Missing	Unknown	130	32.1		
	System	1	.2		
	Total	131	32.3		
Total		405	100.0		

Table P: Any use of weapons

Q	History of firesetting	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	247	61.0	89.2	89.2
	Yes	30	7.4	10.8	100.0
	Total	277	68.4	100.0	
Missing	Unknown	128	31.6		
Total		405	100.0		

Table Q: History of fire setting

R	History of violence	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	49	12.1	17.4	17.4
	Yes	233	57.5	82.6	100.0
	Total	282	69.6	100.0	
Missing	Unknown	123	30.4		
Total		405	100.0		

Table R: History of violence

S	History of sexual offending	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	228	56.3	80.9	80.9
	Yes	54	13.3	19.1	100.0
	Total	282	69.6	100.0	
Missing	Unknown	123	30.4		
Total		405	100.0		

Table S: History of sexual offending

T	History of deliberate self harm/ suicide attempts	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	114	28.1	40.7	40.7
	Yes	166	41.0	59.3	100.0
	Total	280	69.1	100.0	
Missing	Unknown	124	30.6		
	System	1	.2		
	Total	125	30.9		
Total		405	100.0		

Table T: History of deliberate self harm/ suicide attempts

U	Type of work done	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Support/ Joint Working	39	9.6	9.6	9.6
	Relapse Prevention	19	4.7	4.7	14.3
	ASRO Course	1	.2	.2	14.6
	Rehabilitation	6	1.5	1.5	16.0
	Anger Management	1	.2	.2	16.3
	Admit Low/ Medium Secure	5	1.2	1.2	17.5
	Advice	2	.5	.5	18.0
	None	276	68.1	68.1	86.2
	Unknown	56	13.8	13.8	100.0
	Total	405	100.0	100.0	

Table U: Type of shared care work undertaken

V	Patient seen?	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	61	15.1	15.1	15.1
	Yes	273	67.4	67.4	82.5
	Did not attend	8	2.0	2.0	84.4
	More information required	14	3.5	3.5	87.9
	Unknown	49	12.1	12.1	100.0
	Total	405	100.0	100.0	

Table V: Was patient seen?

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"Being interviewed is one of the most abnormal things that you can do to somebody else. It's two steps removed from the Inquisition."

(Zappa 1983)