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Title: How do You Measure a Virtual Object? Assessing the Risk of Releasing Offenders with Mental Health Problems

Abstract

Western societies are troubled by the existence of offenders who commit crimes against the person which are deemed irrational. Reoffending by individuals discharged from mental health services receives particularly intense media and political scrutiny. Forensic mental health professionals are faced with the task of assessing the future behaviour of in-patients whose present secure environment makes current offending unlikely. They are therefore required to assess a virtual object on the basis of patient conduct in an environment which differs to that in which possible future offending could occur. We argue that this problem corresponds to that of ecological validity, as discussed in critiques of the classical psychological experiment. The present paper will explore risk and rationality in relation to data drawn from a qualitative study of staff and patient perceptions of clinical risk assessment in a medium secure forensic mental health unit.

Paper

INTRODUCTION

This paper will explore risk rationality in an arena of major societal concern, that of serious reoffending by ex-patients released from secure forensic mental health services. The paper offers only preliminary thoughts for discussion at the conference rather than a polished analysis. It will be argued that preventative measures, in this case incarceration in secure accommodation, undermine the rationality of assessment for the risks which will arise when these preventative measures are withdrawn, in this case when patients are discharged. Although the research on which this paper is based was undertaken in the specific context of medium/low forensic mental health services, similar issues will arise whenever the value of preventative measures is reviewed. The Introduction will, firstly, place reoffending by forensic mental health service users in a wider societal context as unacceptable risk; then consider the wider challenge to risk rationality posed by prevention; and, finally, sketch out an analysis of how forensic mental health professionals tackle the predicament of predicting future offending in conditions designed to prevent this contingency from occurring. This analysis will provide the starting point for presentation in the findings section of data illustrating the ways in which mental health professionals and service users respond to this paradox of prevention[1].

Societal Attitudes to the Risk of Reoffending by Forensic Mental health Patients

Risk management for individuals who commit serious offences against the person attracts strong media and political attention in the UK and elsewhere. Concern becomes especially heated when the crime is perceived as 'dirty', as in the case of sexual assault, particularly if targeted at children, or is seen as driven by an 'irrational' motive, i.e. a belief system which others regard as delusory. In contrast, non-intentional deaths and injuries, for example those caused on a much larger scale by traffic accidents, and even 'rational' offences against the person, such as those inflicted in bank robberies, attract much less societal angst.

Douglas (1966/2002) has argued that 'primitive' cultures, i.e. small-scale traditional societies which have not developed a high level of role differentiation, use belief systems invoking pollution and taboo to strengthen the weak points of

[1] The term 'prevention paradox' was used by Davison, Davey-Smith and Frankel (1992) to refer to a lack of correspondence between aggregate statistical relationships and individual cases. For example, members of the public are advised to take measures which will lower their 'bad' cholesterol level because a clear relationship between high levels and the statistical risk of coronary heart disease has been identified. However, this relationship could exist even if only a small, but unidentifiable, minority of people were vulnerable. The presently discussed 'paradox of prevention' points to a closely related but distinctive issue, namely the undermining of the evidence base for the assessment of future risk caused by current prevention.

a relatively fragile social structure. She also notes that societies with more complex and robust social structures may employ similar devices when a challenge is sufficiently powerful to threaten their social order, as is particularly the case with ‘irrational’ and ‘dirty’ crimes.

> *Defilement is never an isolated event. It cannot occur except in view of a systematic ordering of ideas … For the only way in which pollution ideas make sense is in reference to a total structure of thought whose key-stone, boundaries, margins and internal lines are held in relation by rituals of separation.* (Douglas, 1966/2002, p. 42)

The release of offenders who have committed irrational or dirty crimes and subsequently reoffend intensifies the threat to the social order exponentially. The offender has committed a crime which undermines cherished culturally mediated ideas about human nature. In addition, society has registered such disturbing transgressions but has failed to prevent them from recurring. However, recognising the distinctive and powerful cultural marking of such reoffending does not require acceptance of the structuralist/functionalist sociological perspective adopted by Douglas. The contrast with comparatively relaxed acceptance of, for example, the unavoidability of the far greater damage caused by traffic accidents could be explained in other ways, for instance in psychoanalytic terms.

The present paper is not concerned with societal attitudes to ‘irrational’ or ‘dirty’ offences *per se*, but rather in the implications of their intense unacceptability for risk assessment and management. Regardless of its psycho-cultural dynamics, the temporary separation of the mentally disordered offender from modern society is accounted for in terms of a framework of risk assessment and reduction, rather than one of pollution and cleansing as in the traditional societies discussed by Douglas. Risk managers are then faced with the problem of predicting the probability of future offending on the basis of observing current behaviour in an environment designed to be as safe as possible, the issue addressed in the present paper.

Ironically, UK medium secure forensic mental health service units were originally conceived of with just this issue in mind. The Butler Committee reviewed discharge and aftercare for mentally disordered offenders (Home Office and Department of Health and Social Security, 1975) in the aftermath of the notorious case of Graham Young. He overtly developed his poisoning skills whilst confined to a special hospital after being convicted for murdering members of his family in this way, and then poisoned work colleagues after his release. Butler concluded that the system might fail to identify a service user’s propensity to reoffend in the remote locations and esoteric environments of high secure (special) hospitals. At this time, risk assessment was a new and relatively unused concept. Tidmarsh (1992) commented that Butler’s 1974 recommendation to set up MSUs were as much concerned with special hospital overcrowding as with risk.

The Young case requires further explication in relation to the thesis of the present paper, that prevention cuts down the rational basis for assessing risks after the preventative measures are removed. It illustrates the opposite case, namely that of risk managers rashly ignoring clear evidence of riskiness. A plethora of UK formal inquiries conducted after a tragedy has occurred following a patient's discharge have made a similar point which is often explained in terms of culpable failures of communication between agencies and between agencies and between agencies and relatives. A recent inquiry into a killing perpetrated by a patient one day after release from a medium secure unit (South West London Strategic Health Authority, 2006) has criticised forensic mental health service providers for becoming too sympathetic to risky patients. As illustrated in the data analysis section below, patients and staff who participated in the present research made a similar point when they argued that compliant patients could progress quickly through the system to discharge simply because they did not cause immediate problems. Without contradicting the above concern, the present paper will explore the converse issue, that preventative measures can undermine the evidence base for risk assessment. The assumption that the risk of a patient reoffending can be supported by *'evidence and rigorous analysis'* underpins the above inquiry report.

> *It might be suggested that this tragedy would not have occurred if it had not been for a single decision, to allow John Barrett out on leave from the medium secure psychiatric unit to which he had been re-admitted on the day before he killed Denis Finnegan. This decision was an essential link in the chain of causation leading to Denis Finnegan's death, but we consider it was only one of several instances where clinical interventions did not give sufficient weight to the risks John Barrett could pose to the public … Too much confidence was placed in clinical judgements unsupported by evidence and rigorous analysis. Ways of working did not facilitate effective discussion and challenge of clinical views. There was a tendency to emphasise unduly the desirability of engaging John Barrett rather than intervening against his wishes to reduce risk.* (South West London Strategic Health Authority, 2006, p.9)

Only a few MSUs were opened in the 1970s and 1980s, perhaps, in part at least, because a convincing case for them had not been made. It was not until another national UK report (Reed, 1992) was published that the number of MSUs increased from a handful to 40 across the UK. Reed presented the benefits of MSUs in terms of them providing a half-way house between special hospital and the community, where service users could be observed and assessed in an appropriate setting. Hence, one of the aims behind the expansion of MSUs in the 1990s was, in our terms as discussed below, to provide a more valid ecology for risk assessment in relation to the communities to which service users would return.

These new medium secure forensic mental health services were internally structured in terms of levels of risk so that service users could gradually progress through environments providing decreasing levels of security and increasing amounts of autonomy (Heyman *et al.*, 2004). This type of social organization, which we have depicted metaphorically as a downward risk escalator, is intended to achieve two linked aims. Firstly, the units offer progressively less structured environments, designed to enable service users to learn to handle progressively greater levels of autonomy via a series of small steps. Secondly, this progression is intended to allow the risk of patients reoffending after discharge to be tested in circumstances ever closer to those of community living. However, the rationality of both strategies can be questioned. It remains unclear how the skills which service users develop in order to cope with highly structured institutionalised environments will equip them to cope with greater freedom. And risk assessment for future offending after release must be based on observations of patient behaviour in the distinctive ecology of the secure unit, the issue discussed below.

The Tension Between Prevention and Risk Assessment

The paradox of prevention arises whenever *colonisation of the future'* (Giddens, 1991, p. 111) through the use of strategies designed to avoid catastrophe is attempted. The pre-Columbian Mexica believed that unless they produced continual military victories, the universe would perish (Conrad and Demarest, 1984, p. 182). As long as they acted in ways which they thought would prevent such an irreversible catastrophe from occurring, the truth of this belief could not be tested. The Mexica would not have evaluated their belief system which was based on a personalistic cosmology in terms of probabilistic reasoning. Moreover, a functionalist explanation of this belief as providing a rationale and motivation for conquest can be readily supplied, as argued by Conrad and Demarest. The present discussion focuses simply on the rationality of this belief system. It illustrates an extreme case in which believers are locked into acting on a prognostication in ways which prevent disconfirmatory evidence from being generated.

Current attempts at future colonisation based on inductive, quantitative risk assessment rely on observing the proportion of cases out of a total of cases versus non-cases, for example the detected rate of reoffending by patients released from secure forensic mental health services (Gray *et al*., 2004). False positive rates[2] can only be determined to the extent to which an outcome is not prevented. Conversely, not preventing outcomes judged highly adverse risks catastrophe and opprobrium for those judged responsible.

[2] More accurately, the false positive rate should be described as the rate at which individuals assessed as being at higher risk turn out to be cases. Also, as implied in the text, the validity of inductive evidence depends on the accuracy of detection. Strictly speaking, evidence-based screening tools optimise for the risk of being detected, in this case for the risk of being caught reoffending.

Van Loon (2002, p. 45), drawing on the ideas of Law (1995), describes risks as 'virtual objects' which are defined conjecturally in terms of a selection from the infinitude of what might happen but, nevertheless, mobilise energy and resources, thereby becoming societally real[3]. Modern epidemiologists do not face the predicament of an imaginary pre-Columbian scientist attempting to assess the impact of human sacrifice on the motion of the sun. Insofar as offenders are released, empirical findings about the predictive accuracy of risk assessment tools can be generated. The analogy with Pre-Columbian methods of future colonisation applies directly only to the minority of individuals who are never released because they are judged too dangerous. With respect to the majority of more run-of-the-mill forensic mental health service users whose offences, however damaging, are not deemed to preclude the possibility of eventual discharge, the problem of risk assessment entails overcoming the obscuring effects of the temporary preventative measures associated with their institutionalisation. Nevertheless, even in this case, the question of whether a patient might have been safely released before their discharge date cannot be rationally answered.

Risk assessment and the problem of ecological validity

The proper focus of risk assessment and management is future or otherwise unknown 'adverse events' (The Royal Society, 1992), or, more accurately, negatively valued events. Sources of concern involving forensic mental health patients might include self-harm, iatrogenic worsening of mental health problems, and being abused by staff, patients or members of the 'community' after discharge. Although such concerns are not totally neglected, they tend to be strongly backgrounded in favour of a primary focus on the risk of reoffending after discharge, and a secondary focus on risks arising from movement down the institutional risk escalator, such as that of absconding. Moreover, because the root cause of these primary and secondary risks is a presumed mental disorder rather than a local bodily condition such as a type of cancer, riskiness gets attached to the person instead of events. In consequence, the forensic mental health service user becomes the risk object. 'Being' higher risk in this sense, i.e. acquiring the status of higher risk as part of one's personhood, may be compared, perhaps fancifully, to being a heretic in the Middle Ages. Heretical and higher risk status are both associated with social exclusion in cultures based on religion and science respectively. Both evoke feelings of revulsion and horror in their cultural context.

[3] One instructive illustration of the pervasive reification of virtual risk objects is commonplace usage of third order constructs of the form that 'person(s) X might be at risk'. If the notion of risk involves second order thinking (Luhmann, 1993/2002, p.219), i.e. a response to possible negatively valued futures, then the idea of possibly being at risk (at risk of being at risk) conveys a further level of reflection. If probability is reframed as uncertainty, then the statement that X might be at risk encodes uncertainty about uncertainty. Although epistemologically problematic, propositions of this sort makes perfectly good sense in everyday usage. This contradiction can readily be understood if the second order risk is considered to take on the attributes of an event, thereby becoming probabilistically analysable.

Health professionals, who will be held accountable with the benefit of hindsight, if a released forensic mental health patient reoffends, are charged with striving to reduce the risk of them harming others after release by assessing their baseline riskiness and progress made, and making recommendations as to when the virtual risk object has shrunk to an acceptable size. Patients also participate actively in this process as their personal futures will be affected by staff view of their riskiness. Staff and, indirectly, patients are faced with the problem of assessing levels of risk in one environment, that of the wider community which patients will live in after discharge, in relation to their observed behaviour in another, that of the secure unit. Obvious differences between the secure environment and that of the world outside for patients include massively reduced autonomy, separation from significant others, dependency on paid staff for meeting basic needs, living almost 24/7 with the same set of people, being compulsorily moved to different sub-environments and being continuously risk assessed.

The problem of assessing post-discharge reoffending risk on the basis of behaviour observed in a secure environment can be compared to that of the ecological validity of the classical social psychological experiment (Orne 1962; 1968; 1981). In both cases, obvious differences between the controlled environment where observations are made and the outside world where conclusions are applied can easily be identified. The validity of any conclusions therefore depends on the correctness of the assumption either that behaviour is insensitive to differences between the environment in which it is observed and the environment of interest or that any significant differences can be adjusted for.

Those who generate this knowledge have a vested interest in defending its rationality by discounting or ignoring the potential impact of such environmental differences. For example, the question of whether theories based on decisions made in conditions of uncertainty in the psychology laboratory can be applied to the world outside remains unacknowledged in Kahneman's overview of a large body of laboratory-based empirical research (Kahneman and Tversky, 2000) concerned with decision-making in conditions of uncertainty. He touches on problem of generalisation, but only in relation to simplification.

> *The principles of the theory [*prospect theory] *should* ***[correct quote]*** *a heuristic benefit in the analysis of more complex decisions, by suggesting hypotheses and by providing templates and labels for the identification of phenomena. For example, although it is surely futile to "test" prospect theory against utility theory in the domain of international relations, the concepts of loss aversion and pseudocertainty are useful tools for understanding strategic decisions. No warranty is implied, of course. The scholars who use the tools to explain more complex decisions do so at their own risk.*
> (Kahneman and Tversky, 2000, p. x1)

This form of rationality depends on the validity of reductionist reasoning. Kahneman and Tversky see *'choice between gambles as the fruit fly of decision theory' (*Kahneman and Tversky, 2000, p. x1). Like the scholars mentioned by these highly cited researchers, health professionals making decisions about the discharge of offenders who have harmed others face a higher order risk. In order to justify the rationality of their risk assessments, they have to assume that observations made in one ecological setting, that of the secure unit, offer predictive value with respect to another.

The critique of the ecological validity of the social psychological experiment can mostly draw upon points which are remarkably obvious when pointed out such as over-representation of psychology students in studies purporting to uncover human nature, the minute significance of experimental outcomes in participants' wider lives, and the contrast between the temporary human relationships established for experiments and ongoing ties with significant others. Orne noted the influence of interpersonal dynamics on the behaviour of 'subjects' participating in social psychological laboratory experiments who would assume that the experimenters were trying to prove their pet theory. He argued that subjects would, on the whole, seek to please by conforming to the implicit 'demand characteristics' of the experimental situation. In turn, the experimenters would employ deception in the hope of preventing the subjects from 'faking good' (or bad), i.e. acting in ways designed to lead to them being classified as posing a lower (or higher) risk. Social psychologists quickly acquired a reputation as devious people whose statements about the purpose of an experiment could not be trusted. The interpretation of findings became increasingly problematic and social psychological experimentation eventually went into decline, losing the status of a dominant paradigm which it had possessed in the 1960s.

Similarly, forensic mental health service users may seek to please their clinicians in the hope of gaining more autonomy. Alternatively, patients may 'fake bad' in order to manage the care system, for example to invoke a therapeutic response or postpone discharge. In turn, clinicians may engage in deception in the hope of seeing through the camouflage of self-presentation in order to uncover a presumed psychological reality which will allow the risk of reoffending to be accurately assessed. The inmates of the asylums studied by Goffman in the 1950s (Goffman 1961) were not subjected to constant risk assessment as they are today. In the heyday of asylums, staff stripped patients of their selfhood, through denying their civil identities and destroying their autonomy so that their personhood could be rebuilt. Currently, risk thinking predominates as an organising principle underpinning the claimed rationality of forensic mental health care perhaps even more than in other arenas of early twenty-first century life.

The process of risk assessment for forensic mental health service users is highly unstandardised in the UK and elsewhere. It involves a mix of case conferences, attended by involved disciplines such as psychiatrists, nurses and social workers and by patients whose role is often marginalised, external tribunals who must

approve major changes to patients' status, and, increasingly, but variably, risk assessment 'instruments' (sometimes referred to more informally as 'tools'). These tools are comprised of items on which patients are rated, generating summative scores deemed indicative of patients' level of riskiness with respect to reoffending after discharge. They can be divided into three types (Gray *et al*., 2004). Firstly, actuarial measures are based on easily determined biographical information covering offending history and demographic factors inductively associated with the probability of reoffending (or more accurately, the probability of being caught and convicted for reoffending). An example is the Offender Group Reconviction Scale [OGRS] (Copias and Marshall, 1998). A second type of risk assessment tool involves psychological checklists such as the Psychological Checklist, Screening Version [PCL-SV] (Hart, Cox and Hare, 1995). Thirdly, risk assessment inventories, most popularly the Historical, Clinical and Risk Management Scales [HCR-20] (Webster, *et al* ., 1997) which will be discussed further below, offer a systematic approach to assessing an eclectic mix of biographical, psychological and environmental risk factors. Gray *et al.* (2004) concluded from their correlational study that the actuarial instruments predicted the risk of forensic mental health patients being convicted for reoffending within two years fairly accurately, with about 75% reconvicted for major or minor offences in the high risk group and 17% in the low risk group. They also concluded that non-actuarial factors provided virtually no predictive accuracy.

Unfortunately, the value of actuarial risk assessment for health professionals concerned with safe rehabilitation is limited by the immutability of items such as patient gender and offending history. Perhaps for this reason, the HCR-20 has become the most popular risk assessment tool. The items covered are summarised in Table One below.

TABLE ONE
RISK ASSESSMENT DOMAINS COVERED BY THE HCR-20

Historical	Clinical	Risk Management
H1 Previous violence	C1 Lack of insight	R1 Plans lack feasibility
H2 Young age at first violent incident	C2 Negative attitude	R2 Exposure to destabilisers
H3 Relationship instability	C3 Active symptom of major mental illness	R3 Lack of personal support
H4 Employment problems	C4 Impulsivity	R4 Non-compliance with remediation attempts
H5 Substance use problems	C5 Unresponsive to treatment	R5 Stress
H6 Major mental illness		
H7 Psychopathy		
H8 Early maladjustment		
H9 Personality disorder		
H10 Prior supervision failure		

Half the items involve immutable historical factors, making it particularly difficult for those with high scores to graduate into a low risk category unless they perform outstandingly in the areas covered by the other two columns. However, the instrument is intended as an aid to holistic but systematic judgement of risk rather than as a numerical indicator (Gray *et. al.*, 2004). Nevertheless, the items which can be changed, a mix of situational indicators such as lack of support, and personal attributes such as 'negative' attitude take on strategic importance in relation to the perceived success of interventions designed to reduce patient riskiness.

Consideration of these items brings the analysis back to the question of how practitioners attempt to assess them in ways which are ecologically valid. The research discussed below aimed to explore service user and provider understandings about this risk assessment task.

METHODOLOGY

The qualitative data discussed below are drawn from a series of studies undertaken in one UK medium/low secure forensic learning disabilities (Heyman, Buswell-Griffiths and Taylor, 2002) and two forensic mental health service units (Heyman *et al*., 2004; Davies *et al*., 2006) located in NE England and London respectively. A comparative study is being undertaken in South Africa but is not included in the present analysis. The methodology of these studies is discussed in the cited papers and will only be briefly outlined here.

The studies have been designed to explore forensic mental health staff and service user perceptions of risk assessment and management in relation to the attempted rehabilitation of the latter. They have been conducted in two stages, with general staff and service user interviews followed by detailed case studies of

individual patients. The case studies included, as far as possible, interviews with the patient and associated staff, observation of ward rounds and case conferences. Repeat interviews with case study patients and staff were conducted, where possible, about a year after initial interviews so that perceptions of progress could be explored in relation to views expressed earlier. A project currently being undertaken in London combines interviews with ethnographic observation.

A grounded theory approach to design, data collection and analysis was adopted, with data collection and analysis undertaken concurrently so that subsequent interviews could take up emergent issues. Approval from a UK NHS Ethics Committee was obtained for each study. Findings have been fed back to the participant organisations in order to provide opportunities for comment which has been taken on board in final versions of papers and reports.

DATA ANALYSIS

This conference paper offers an initial analysis, based on discussion of selected qualitative data, of the impact of the paradox of prevention on risk assessment and management in forensic mental health service settings. The analysis will be presented in two sections: firstly discussing staff and patient perceptions about the problematic ecological validity of risk assessment, with particular reference to the paradox of prevention; and, secondly, considering staff attempts to overcome such problems in relation to patients' efforts at managing their own risk status.

The problematic ecological validity of risk assessments

Data analysis suggests that risk management is pervaded by uncertainty about how patients will behave after discharge. As argued above, this problem arises when a virtual risk object, namely the risk of a patient reoffending after discharge, a presumed attribute of the person, has to be assessed in a secure environment designed to prevent offending. This inherent uncertainty can be contrasted with the official purpose of medium secure units, articulated in the Butler Report, of providing a setting more similar to that of the external world in which risks can be properly assessed. Confidence in this mission was expressed by one senior professional who occupied a position at the top of the management hierarchy.

> *We should take somebody who has committed an offence while they have been unwell. Bring them in here and be able to, it could be that it is homicide, but bring them in here and treat them and be able to put them back in the community somewhere around eighteen months to two years.* (General Manager, forensic mental health unit)

As illustrated below, staff who worked closer to the front line of care often expressed less confidence that rational decisions about discharge risks could be made. This comparison suggests the hypothesis that those who occupy role

positions close to the top of the organisation may be more likely to accept the validity of its official mission than those lower down. In contrast to the general manager quoted above, one ward manager, discussing progress through the forensic unit towards, and sometimes away from, discharge believed that 'it's *more luck than anything'*.

> *I think that we're such a mixture here of people and patients with difficulties. We're now dealing with someone with such an extensive forensic history, and such complex needs, that often there's no clear evidence that things have moved forward.* (Ward manager, forensic mental health unit)

The same respondent saw the predominance of chance in the face of efforts to assess and reduce risks rationally as arising from the contrast between their complex needs and the procedures available for cycles of risk reduction and assessment.

> *If someone's worked well within the Home Office* [requirements], *and had their 12 community trips, and everything has gone according to Home Office plan, but there's still huge anxieties. Because the traits of the personality were, are, still in place, then, the doctor will, may well, the team will turn round and say, you know, 'He can go to low secure'. But, again, … they would transfer responsibility to going back into the community and to another RMO* [responsible medical officer] *which, with this particular chap's history,* [would mean] *a huge chance he will offend again. But he'd done everything by the book ... If he has done everything by the book then he will be discharged.* (Ward manager, forensic mental health unit)

This analysis suggests that, the forensic health care system responds to the paradox of prevention by proceduralising risks which cannot be rationally assessed. Patients, who do what is required of them, enabling the appropriate boxes to be ticked, are deemed safe enough for discharge. According to this respondent, uncertainty resulting from the inherent flimsiness of the evidence base underpinning such decisions is mitigated, at least for those making them, by the transfer of risk ownership.

The idea of the implicit demand characteristics of the experimental situation played a central role in Orne's challenge to the ecological validity of the experimental situation, discussed above. As the above quotation suggests, one of the strongest demand characteristics of the forensic mental health care environment is for patient conformity.

> *Patients get worn down really, not really being cared for. But you're beating your head against the wall so many times, so you just accept what's going on. It's not really that you become all that better. You've just accepted what's going on … I think it's just a case of getting used to the environment, or the rules and regulations.* (Charge nurse, forensic mental health unit)

The above quotation differentiates improved mental health from learning to conform, a process which, in another context, might be called subjugation, or breaking the will to resist. This *de facto* operational reliance on inducing conformity as a means of reducing risk raises two problematic issues associated with the lack of correspondence between displays of conformity and reduction in riskiness. Firstly, risky patients may be discharged because they have learnt to meet the demand characteristics of the situation. Secondly, patients who pose little risk may become trapped in the system because they cannot bring themselves to conform.

The service user quoted below believed that sex offenders could 'run' through the system because they complied with its demand characteristics even though their underlying riskiness was not tackled

> **Interviewer:** *What sort of ones* [patients] *do you not get on with?*
> **Patient:** *I don't like the ones who go and … sex crimes and that … What makes me mad about this place, right, is the fact that, like I say, people running through the system and all that right … And then you've got, like, on a Saturday, they go down to* [local town] *by themselves. And owt could happen. Anything's* [i.e. children] *around on Saturday.* (Forensic learning disabilities service user)

Qualitative research cannot demonstrate the extent to which conformity speeds up release. The strategies which staff adopted in order to try to see through patient efforts to manage their own risk status will be discussed in the next section. Nevertheless, this example does illustrate a concern about the ecological validity of risk assessments undertaken in secure units which is similar to that discussed by the ward manager quoted above.

Conversely, patients who, for whatever reason, cannot comply with the demand characteristics of the medium secure unit may find that their progress is blocked even though the relationship between issues arising in this environment and riskiness in the outside world is problematic. Consultants at a medium secure forensic mental health unit expressed alarm at the behaviour of a patient who had visited other wards without permission with hair cutters because he wanted to earn money as an amateur barber. In a community context, this activity might be viewed as commendably entrepreneurial or, at least, as typical Cockney (London East End) canniness. In the forensic environment it was seen as an indicator of serious riskiness.

A major cause of patient non-compliance was failure in managing anger. Expressions of anger may provide a valid indicator of post-discharge riskiness, depending upon the triggering context and how anger is expressed. The patient quoted below felt that a trivial action had been wrongly classified as an indication of aggression.

> *Well, about for instance. I walked across to the table, the pool table, tapped on the top of it, and she* [the nurse] *wrote down that I was feeling aggressive, and that, and all things like that. And I just thought, 'Well, one tap on the table'. I thought that was entirely wrong. So I said. She discussed it. It came out in the ward round. That, she wrote that, which was wrong, out of order.* (Forensic mental health service user)

Patients and staff occupy an enclosed, highly frustrating environment in which endemic interpersonal conflict may be expected. In addition, patients may be subjected to minute observation designed to test their current riskiness. This combination of close confinement and total risk assessment may obscure the issue of primary concern, namely the likelihood of a discharged patient reoffending.

The final illustrative example of problematic ecological validity discussed in this section is of particular interest because it reveals the possible rationality underlying the apparently negligent discounting of statements of intention to offend.

> *He* [patient] *said that he wanted to* [commit serious offences]. *And they still let him go because he turned round and said, 'Well, I made it all up. I just wanted to go and see my mum' … So, you know, as a nursing team the day before we had sat around just kind of gob-smacked that the consultant had said that he could go … I would not escort him.* (Health care assistant, forensic mental health unit)

This patient's tactic may have worked because the consultant viewed his behaviour as symptomatic of illness, and prescribed a home visit. When asked why the consultant had agreed to his parole, a decision which the above respondent regarded, ironically in this treatment context, as *'complete madness'*, she cited the reason given in the patient's medical notes, namely *'to allay his* [patient's] *anxiety'*. Outside forensic mental health contexts, people often make threats, such as 'I will kill you' which are not taken literally. The forensic context frames such statement as potentially threatening. Health professional risk managers are faced with the task of differentiating serious statements of intent from merely metaphorical threats. In this case, doctors felt that they knew the patient well enough to rule out real risk of offending. However, if their judgements prove with hindsight to have been incorrect, they will be held to account by judges of responsible risk-taking who lack access to the many other occasions in which threats were not translated into action.

Strategies for managing the problematic ecological validity of risk assessments

Staff and patients expressed awareness of the problematic validity of risk assessments, as illustrated above, and staff developed a number of strategies for attempting to detect the virtual object of concern to them, namely the risk of a patient reoffending after discharge. In general, the data suggest that staff gave more attention to reducing the risk of released patients reoffending than they did to that of detaining patients unnecessarily. Not surprisingly, patients did not, in general share this prioritisation of their own riskiness, and were mostly concerned about being detained unnecessarily. As might be expected with respect to this example of the safety *versus* autonomy dilemma, which is fundamental to all risk management, staff leaned towards safety and patients towards autonomy. Three strategies which staff adopted in order to assess the safety of discharging patients in conditions of low ecological validity are discussed below: discounting good behaviour; mini-trials; and formalised risk assessment.

Discounting good behaviour

Given that patients mostly, but not always, wanted to be released as early as possible, they might be expected to attempt to act in ways which would reduce their assessed risk status. Staff, in turn, might try to see through such attempts at self-presentation in order to minimise the risk of released patients reoffending. One forensic learning disabilities worker, discussing this issue, said that (male) patients would be asked questions designed to test their truthfulness such as whether they would look at a woman with large breasts! This approach provides an obviously fragile method for attempting to discover the risk virtual object. A psychiatrist attending a feedback session for one of the projects undertaken in a forensic mental health unit indicated that staff might deliberately withhold revealing the purpose behind an activity involving a patient so that it could be used as a test of their underlying disposition (i.e. riskiness). The *'star patient'*, discussed next, was seen as operating a policy designed to reduce his assigned risk status and thereby maximise his prospects of early release.

> *Every time I stop, 'Oh I'm fine, I'm alright'. 'Have you got anything you are worried about?' 'No.' … He's all pleasant. He looks normal ... We know he is the 'star patient' and everything, but* [laughs] *we have to watch him,* [given] *what he did before, you know.* (Primary nurse, forensic mental health unit)

The patient's conduct is seen as too good to be true. This suspicion is framed by awareness of the seriousness of his previous offending, illustrating the difficulty which patients experienced about compensating for historical, unalterable risk indicators. Patients faced with this double bind perhaps needs to adopt a more subtle approach, first 'faking bad' so that their subsequent conversion to low riskiness might appear more credible.

Mini-trials

Testing through mini-trials involved allowing a small temporary increase in autonomy, in the hope of being able to assess whether any signs of reoffending would occur whilst, at the same time, avoiding adverse events. This strategy had been adopted with the 'star patient' discussed above.

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

The strategy can be compared to that sometimes adopted for inductively testing the safety of novel foods by eating progressively larger amounts after checking whether the previous dose caused any ill effects. It allows the riskiness of a patient to be assessed in environments more ecologically similar to the outside community than the secure unit. Its limitations can easily be identified. As the above respondent indicates, a risk of disaster is inescapably incurred. Conversely, patients might conceal or be able to control their offending proclivity until discharged.

Formalised risk assessment

Risk assessment tools such as the HCR20 provide a means for systematically considering the factors which might be associated with the risk of a patient reoffending. However, as argued in the Introduction, the historical factors which can be assessed relatively easily cannot be changed, whilst assessment of those associated with the patient's presumed mental state and personality raises ecological validity issues. These tools can be utilised in a more symbolic way, to proceduralise risk assessment so that completion of the tool serves as a substitute for confronting uncertainty about patients' future behaviour in a different environment, as illustrated by the final example, derived from observation of a ward round. The consultant quoted came in at the tail end of a lengthy discussion concerning difficulties arising from the ward management of a female patient, including conflicts about bathing and money matters, and accusations directed at male staff.

> **Consultant:** *What risk assessment was done. The pink thing? Do we need to assign numbers?* [Senior house officer reads out numbers from the ward round summary.] *Make a point of noting risk to others on the ward round minutes and notes. We need to be vigilant.*
> [Next patient] (Ward round, forensic mental health unit)

The reading out of risk 'numbers' combined with an admonition to caution brings a sense of closure to the discussion, conveying a sense that an authoritative,

scientifically rational resolution has been achieved, even though it is disassociated from the difficult daily living problems discussed. Assessment of patient progress towards a level of riskiness which would justify their discharge relies on observation of how they respond to the environment of the secure unit, even though many of the issues which arise, as in the last example, bear little relation to those which would be of concern in the ecology of the outside world.

CONCLUSION

Social scientists should not claim the right to decide on the appropriate balance between safety and autonomy in societal responses to people who have harmed others by committing offences against the person. With respect to those whose offences are judged to result from a mental disorder, this response involves treatment rather than blame. Ideally, accurate risk assessment would allow individuals who are going to reoffend to be detected and detained and every other forensic mental health patient to be released. Such perfect predictive accuracy is clearly unattainable, except with hindsight, from which vantage point accusatory accounts of service failure can easily be constructed. The future behaviour of individuals cannot be accurately predicted, particularly in terms of modifiable factors such as insight and mental state. Therefore, a politically negotiated balance must be struck between the commendable aims of rehabilitating offenders and protecting the public together with its sense of the moral order. However, in the present political climate, staff are, in effect, asked to eliminate the risk of reoffending completely, an impossible predictive task. In this climate, some patients will never escape from their higher risk status and resulting incarceration because of their offending history, but must meet behavioural requirements designed to bring about safe release. They become trapped in the least secure environment, having met all the requirements for release. Conversely, other patients whose risk assessment indicates that they can be safely released may develop ‘gate fever’. This term was used in one forensic mental health unit to depict patient behaviour designed, however unconsciously, to increase their riskiness so as to postpone release and its consequent problems.

Although social scientists cannot claim expertise concerning how such a balance should be struck, they can critically analyse the rationality of socially constructed risk virtual objects. In the case of the risk of forensic mental health patients reoffending, this critical analysis can include questioning of selective attention given to the severe but highly infrequent harm caused by such offences. In addition, the strong attribution of riskiness to the person, which leads to the patient, rather than the environment or person/environment interactions becoming the risk object, can be challenged. However, the present paper focuses on the problem of assessing this already constructed risk object, the task which service providers are faced with.

It has been argued in this paper that the rationality of risk assessment in the forensic mental health service context is undermined by the paradox of prevention. Probabilistic reasoning depends upon induction, observing the rate at which an event occurs under specified conditions and then assuming that this rate will continue to hold in the future. Although rates appertain to categories and not to individual events, they can be assigned heuristically to individuals, so that an individual is deemed to carry the probability (rate) observed in the category to which that case is assigned. However, the paradox of prevention precludes inductive reasoning because individuals are placed in an environment designed to stop the adverse event of concern from occurring. Although the present paper has focused on the issue of reoffending by discharged mental health patients, the idea of the paradox of prevention can be applied to any risk management context in which future risk has to be assessed when preventative measures are already in place.

This paradox was illustrated in the Introduction, perhaps fancifully, with the example of pre-Columbian civilisations such as the Mexica which practised violent activities in order to ensure that the sun rose in the sky. This example demonstrates that the paradox of prevention arises with respect to attempted colonisation of the future by any means, including placating the gods, rather than from risk rationality *per se*. It was argued in the Introduction that the paradox of prevention is particularly likely to trap decision-making in a loop which is cut off from disconfirmatory evidence when the contingency of concern is culturally abhorred, as in the case of ‘mad’ or ‘dirty’ offences against the person. However, less culturally charged examples can easily be identified. Crohn’s disease provides an illustration of the operation of the paradox of prevention at the personal level. This condition causes inflammation of the bowel, giving rise to chronic symptoms such as fatigue and weight loss. In addition, periodic ‘flare-ups’ causing severe and sometimes life-threatening symptoms such as blood loss commonly occur. Flare-ups can to some extent be controlled through the prophylactic use of non-steroidal anti-inflammatory drugs. Although cleared for long-term use, these drugs, as with all pharmaceutical interventions, carry their own iatrogenic risks. In about a third of cases, the patient experiences only one major flare-up before anti-inflammatories are prescribed. Such patients are faced with the paradox of prevention. If they stop taking these drugs they may experience a further flare-up which, through a process of positive feedback may make further events more likely. On the other hand, if they continue to take anti-inflammatories, they increase their risk of suffering unwanted side effects. Like the Mexica, but at the personal level, they are trapped in a set of circumstances which make the rationality of their future management strategy untestable.

The paradox of prevention can be escaped if proxy measures associated with a virtual risk object, such as being a person who would reoffend after release, but unaffected by the operating preventative measures could be identified. The efforts of staff and patients to build a rational risk management framework involved obviously flawed endeavours designed to find this kind of indicator such

as discounting patient self-presentation strategies, using mini-trials and relying on the apparent precision of numerical risk assessments.

Practitioners are entitled to ask what on earth they are supposed to do in response to such challenges to the validity of the risk assessments on which the rationality of their decision-making depends? Three constructive suggestions can be drawn from the present analysis. Firstly, societal expectations about the potential of risk assessment in this and other domains affected by the prevention paradox need to be reduced, so that a *de facto* risk avoidance strategy is replaced by one of risk taking which recognises the legitimacy of reasonable risk (Titterton, 2005). Secondly, service users can be engaged in the assessment and management of the risks which they may pose (Langan and Lindow, 2004) rather than being deceived like the 'subjects' of classical social psychological experiments in order to prevent them from concealing their real riskiness. Thirdly, the current blame culture directed at forensic mental health services can be mitigated if inherent limitations to the risk assessment resources at their disposal are recognised.

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