

**PROBLEMS OF OFFENDERS WITH MENTAL DISORDERS**  
**A PLURALITY OF PERSPECTIVES WITHIN A SINGLE MENTAL HEALTH**  
**CARE ORGANIZATION**

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Managers, doctors, nurses, occupational therapists, social workers, psychologists, unqualified staff and service users were interviewed for a qualitative study of risk management and rehabilitation in an inner city medium secure forensic mental health care unit. Different professional orientations to service user problems were identified. Doctors focused primarily on the diagnosis of mental disorder, which they managed mainly through pharmaceutical interventions. Psychologists were principally concerned with personal factors, for example service user insight into their biographical history. Occupational therapists concentrated mainly on daily living skills, and social workers on post-discharge living arrangements. Some front line nurses, held accountable for security lapses, adopted a criminogenic approach. Service users were more likely than professionals to understand their needs in terms of their wider life circumstances. These differences are explored qualitatively in relation to four models of crossdisciplinary relationships: monoprofessional self-organisation combined with restricted communication; hermeneutic reaching out to other perspectives; the establishment of interdisciplinary sub-systems; and transdisciplinary merger. Relationships between professions working in this Unit, as portrayed in qualitative interviews, corresponded mainly to the first model of monoprofessional self-organisation. Reasons for restricted crossdisciplinary understanding, particularly the wide power/status differences between the medical and other professions, and between staff and patients, are discussed.

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## **MAIN TEXT**

### **INTRODUCTION**

This paper will explore professional and service user perspectives in one troubled, politically sensitive arena, that of forensic mental health care. Qualitative data obtained in a study of one UK medium secure unit will be utilised to illustrate the diversity of frameworks employed to understand service users' problems. Crucially, the images of other types of participant which respondents constructed from these frameworks will be explored. Four ideal typical models of crossdisciplinary relationships are outlined below. The paper will consider their applicability to accounts of forensic mental health care service user problems. The impact on problem definitions of social power differences between the medical and other professions and between staff and patients will be discussed in relation to the data analysis.

The term 'profession' will be used broadly in this paper to refer to occupational groupings which make culturally endorsed claims that their work is guided by a disciplinary knowledge base. The professions clinically involved in forensic mental health care include medicine, psychology, social work, occupational therapy and nursing. Collaborative working between professions is variously described in the literature as 'multiprofessional', 'interprofessional' or 'transprofessional', implying a progressively greater degree of synthesis. The term 'professional' can be replaced by 'disciplinary', drawing attention respectively to a body of practitioners and to the knowledge base which legitimates their claim to societal recognition as a profession. 'Crossdisciplinary' will be used in the present paper as a neutral term encompassing different levels of integration of professional knowledge, the focus of the paper.

A disciplinary knowledge base offers a mass of detailed, continually evolving technical knowledge underpinned by more stable, broader presuppositions about the nature of the problems which the profession is concerned with (Abbott, 1988). Disciplinary perspectives encompass multiple levels of analysis, are affected by differences between intradisciplinary schools of thought, and shift historically. Nevertheless, they are characterised by distinctive zeitgeists which can often be evoked by a much-used phrase, such as 'disease' in medicine, 'care' in nursing, 'people' in psychology, 'daily living skills' in occupational therapy and 'environment' in social work. When members of different professions interact in the care of service users, they are exposed to, and more or less affected by, each other's discipline. Many different types of mixing of disciplinary world view may be envisaged. Abbott's (1988) seminal analysis of professional jurisdictions provides the starting point for the present analysis. Abbott viewed professions as simultaneously interdependent and competing for power, status and resources. The tension between these two states puts relationships between

professions into constant flux. Review of the theoretical literature has led the present authors to identify four ideal typical forms of relationship between professional disciplines: monoprofessional self-organisation (autopoiesis); hermeneutic reaching out; partial interdisciplinarity; and full transdisciplinary merger. These four ideal types illustrate only some of the many possibilities for one-way and multiple influence between disciplines.

Luhmann (1984) emphasised the propensity for professions to evolve as separate self-organising social systems with distinctive presuppositions, identities, traditions and regulatory structures. Luhmann argued that autopoiesis enhances communication within professions at the expense of impeding that between them, generating endemic cross-professional misunderstanding. Van Loon (2002), adopting a hermeneutic approach (Habermas, 1984), considered Luhmann's view of crossdisciplinary collaboration over-pessimistic. From the perspective of 'communicative rationality', social actors are capable of viewing the world through the eyes of others via meaningful communication. This capability may be impeded by gross power differences. Leydesdorff (2003) has suggested that the approaches of Habermas and Luhmann can be combined. He argued that the interactions of separate self-organised systems can generate new autopoietic sub-systems, islands of interdisciplinarity within organisational seas of disciplinary separateness. The upper limit of disciplinary merger involves the emergence of a new 'transdiscipline' in which the separate identities of the individual professions are lost. For example, Cherin *et al.* (2000) argued that a transdisciplinary approach to home care for terminally ill HIV/AIDS patients enabled care workers to operate from a '*biopsychosocial perspective*'. Although presented by Cherin *et al.* and others as the preferred structure for crossdisciplinary knowledge, transdisciplinarity generates new issues. Firstly, disciplinary merger creates a new discipline with its own presuppositions, biases and autopoiesis. Secondly, it undermines one of the main gains of specialisation, collective grasp of a continually accumulating knowledge (Abbott, 1988, p. 179).

The present paper will not address the question of which model best depicts interdisciplinary relationships in the Unit, a task requiring extensive direct observation. Instead, the paper will consider the correspondence between participant **accounts** of service user problems to these four ideal types.

Little research on professional views of their own discipline in relation to others, and of service user views, has been undertaken in forensic mental health care. The problem(s) which these services deal with are ill-defined, creating fertile ground for crossdisciplinary misunderstandings. The title of Prins' (1995) book asks whether those categorised as mentally disordered offenders are '*offenders, deviants or patients?*'. Their liminal status (Warner & Gabe, 2004) invites attention from a range of services and professions, and raises the mind/body problem. The dominant position of doctors in forensic mental health services encourages medical interpretation (Whyte & Brooker, 2001; Coffey & Jenkins, 2002). However, its fitness for purpose has

been strongly challenged, particularly in relation to the problematic concept of psychopathy/personality disorder (Manning 2000). The assumption that psychiatric illness precedes offending may not encompass the problems of most forensic mental health service users (Vivian-Byrne, 2001). These include psychological symptoms, an offending history, addiction to illegal substances, marginal socioeconomic status and lack of a social support network.

The limited available evidence suggests that the extent of unrecognised divergences of disciplinary perspective should not be underestimated. Hutschemaekers, Kaasenbrood and Tiemens (2005) explored the '*collective sense of the profession*' of mental health professionals by asking members to make clinical judgements on case study notes. Profession proved to be a much stronger predictor of judgement than service user characteristics. Moreover, mental health practitioners working in multiprofessional teams may feel that the other professions do not understand their discipline (Callaghan and Larkin, 2005). Multiprofessional provision of secure mental health services has been long recommended (DHSS, 1975), but not necessarily achieved (Hodgins, 2002).

Studies of single professionals have documented intradisciplinary differences of perspective. Strauss, Schatzman, Bucher, Ehrlich, & Sabshin (1964) categorised the approaches employed by professionals working in a Chicago psychiatric hospital as biological, psychological or social. However, this study preceded the discovery and widespread adoption of psychotropic drugs, a development associated with vigorous biomedical expansionism (Barker, Baldwin & Ulas, 1989). Ethnographic (Clarke, 1996) and vignette-based (Mercer, Richman, & Mason, 2000) studies suggest that forensic mental health nurses are polarised between those who adopt therapeutic and custodial approaches. Their holistic starting point, combined with lower overall occupational status, may make it particularly difficult for mental health nurses to establish a strong, unified identity (Baldwin, 2002; Gillen, 2005). Such findings indicate that the disciplinary bases of professions are themselves not monolithic.

The present paper will explore professional and service user understandings of service user problems in relation to the array of disciplines attempting to deal with them. The findings will be related in the Discussion to the ideal types outlined above, with particular reference to the emergent issue of the impact on crossdisciplinary thinking of social power differences between medical staff and other professionals and between staff and service users.

## **METHODOLOGY**

A more detailed account of the study methodology is given by Heyman, Shaw, Davies, Godin & Reynolds (2004). The Unit which provided the setting for the present study is located in a deprived inner-city area of London. It caters for about 100 service users, around 90% male, and draws a good

proportion of its participants, particularly service users and junior nursing staff, from diverse black and ethnic minorities. The largest non-British born groups are of black African and Caribbean origin.

The fieldwork, modelled on previous research completed in a medium/low secure forensic mental health facility for adults with learning disabilities (Heyman, Buswell-Griffiths & Taylor 2002), was carried out between 2000 and 2003. The NHS Local Research Ethics Committee approved the research. Participants received a printed information sheet and consent form. In the first of two study phases, 44 staff interviews were undertaken in order to explore professionals' views about the Unit, and to guide directions of enquiry for the second phase which focused on the problems and prospects of 10 service users. Organisational issues and refusal of consent precluded the acquisition of complete data sets for each service user participant. Instead, the aim of data collection was to obtain as many perspectives as possible on each service user, so that similarities and differences between service user and staff perspectives could be qualitatively explored. The overall pattern of data collection is summarised below.

#### **INSERT TABLE 1 HERE**

As shown in Table One, at least one staff member was interviewed for nine of the 10 phase two service users. One service user declined consent for any staff member to be interviewed about his case. Three service users were reinterviewed about a year after the initial interview so that developments could be reviewed. Of the other seven service users, two declined a second interview, four were discharged before this interview was due to take place, and one died during the study period. Case conferences for two service users were audio-recorded and transcribed, and detailed notes were taken about a second case conference concerning one of these service users. This limited data will be drawn on only slightly, as the paper focuses on professional and service user perspectives.

Lightly structured phase one staff interviews were organised around topics which included: the aims of the Unit and the respondent's own role; what works well and barriers to the delivery of high quality care; issues arising from service user movements through the wards; and formal and informal risk assessment processes. In phase two interviews, service users were asked particularly about the following issues: how they were getting on; what moves they had made through the wards, and how the moves had come about; how they viewed their future; and what risks were reduced or increased by their residence in the Unit. Staff were asked to confidentially discuss the service user's problems, needs and prospects. Frequent visits and informal contacts with Trust staff allowed the researchers to interpret interview data in relation to the cultural milieu of the Unit. Seven presentations to Trust staff have been given, and have produced further insights into perceptions of care and multidisciplinary working.

Most of the 73 interviews undertaken and case conferences observed were recorded and fully transcribed for analysis around thematic categories. Nine interviews were recorded in note form, because of recording problems (six), use of unanticipated opportunities to undertake interviews (two), or service user preference (one). Interviews are quoted verbatim, with respondents identified through pseudonyms. Information which might identify individuals has been removed.

A grounded theory approach to data analysis based on a symbolic interactionist theoretical framework was adopted (Strauss and Corbin, 1990). This approach attempts to discover participants' perspectives, aims and tactics in specific social contexts. Data collection and analysis were undertaken concurrently so that emergent issues could be explored further. Transcribed interviews and case conferences were analysed through the sorting of extracts into thematic categories which were linked to interpretative notes. Standard wordprocessor facilities such as embedded comments were used for this purpose. As analysis progressed, interpretative notes were attached to thematic categories, and categories were related around a central issue, namely multiple definitions of service user problems. These types of analysis correspond to the processes of open, axial and selective coding respectively (Strauss and Corbin, 1990). Transcripts were coded by members of the research team, and discussed at regular research meetings. Data interpretations were checked with Unit staff at feedback sessions, as described above. However, judgement about the validity of the interpretation of qualitative data rests ultimately with the reader.

## **DATA ANALYSIS**

The data analysis will compare staff and service user understandings of the latter's problems. Problem definitions framed in terms of disease, criminal propensities, personal biography, current circumstances and substance misuse and their combination will be considered. Particular attention will be given to respondents' views about others' perspectives.

As illustrated below, problem definitions can be loosely mapped onto professional/service user groupings. Doctors mostly saw their primary function as curing disease by changing the biochemistry of the brain. Psychologists concentrated on tackling biographically rooted problems. Occupational therapists were mainly concerned with daily living skills, and social workers with service users' social environment. Mental health nursing emphasises a holistic approach to the whole person. However, some nurses stressed the need to contain forensic risk which they saw as overlapping but partially separable from mental disorder. This criminogenic focus can be explained in part by their accountability for security breaches. Service user accounts of their problems tended to reference their specific personal circumstances (e.g. significant relationships) as against the generalised clinical, criminogenic or environmental processes discussed by staff. Finally,

a few respondents saw illicit substance use as a neglected issue which exacerbated criminogenicity and/or mental disorder. These last two issues, which did not correspond to organised professional disciplinary concerns, tended not to be picked up.

### **The Medical Model**

Doctors, who enjoyed the highest status and wielded most power in the Unit, believed that it should function as a hospital in which mental illness was mostly treated through pharmaceutical interventions. Clair, a consultant psychiatrist, defined the aims of the Unit as *'the alleviation and prevention of deterioration of mental disorder in its broadest sense'*. She ascribed the sexual harassment of staff by one service user to *'erotomania'*, constructing a distinct disease entity corresponding to a type of social deviance. Cameron, another consultant psychiatrist, objected to the researchers' use of the term 'medical model' on account of its implication that alternative frameworks could be offered, insisting that *'this is a hospital'*. Such comments can be understood as 'regression', i.e. the turning inwards of a profession which has accumulated social power (Abbott, 1988, p. 118).

Even doctors' acknowledgement of the significance of other professions could assert the superordinate explanatory power of the medical model.

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

This transdisciplinary analysis subtly affirms medical primacy in the representation of a multiprofessional cascade of interventions. The account starts from a disease, psychosis, which is cured through a pharmaceutical intervention. Other disciplines are then drawn upon to sort out consequent, implicitly secondary, problems such as acknowledging offending and lack of daily living skills and resources. Nursing, the largest segment of the workforce, is not mentioned. Members of other professions frequently acknowledged the primacy of the medical model. Graham, a service manager, spoke of *'putting them [service users] back into the community'* after their *'illness has been eradicated'*. Kunle, a frontline qualified nurse saw his role, in the first instance, as *'working closely with their therapy, allowing them to gain some insight into their mental illness'*. The concept of insight could take on different meanings depending upon whether a medical or existential framework was adopted.

Challenges to the medical model placed other professionals, particularly more senior staff, in the awkward position of undermining the legitimacy of the organisational culture in which they were embedded. Tension between rejection and acceptance of medical predominance is apparent in the next quotation.

*I find the medics medicate and that's it. I don't see enough of other therapies ... We could be here until the cows come home just concentrating on offending behaviour, and some consultants would say, 'OK, we'll treat illness'. It's a big debate in forensic psychiatry ... I would be worried if all you do is look at offending behaviour because, at the end of the day, I believe that we're a mental health care setting, you know. Let's get the illness stabilised. Let's not let the offender overtake. There's other people that can pick up the offending behaviour. But it's clouded.* (Norman, nurse manager)

The above respondent first criticises the primacy of the medical model, as operationalised in pharmaceutical interventions, then prioritises getting illness stabilised, and finally acknowledges that problem definition is 'clouded'. Some staff members, often in more junior positions, and service users challenged the view that the Unit ameliorated illness through pharmaceutical intervention:

*It [the Unit] sometimes feels like a nice new building to house people they don't know what to do with. So we'll pump them full of medication and sit them in the smoking room.* (Isabel, health care assistant)

Service users' views about the medical model varied. Stan, who was praised by staff as a model service user, and was being prepared for discharge, said that he would 'continue taking medication, as I know why I need it'. How far he had internalised a medical framework or was using displays of compliance tactically to speed his discharge, is not known. Other service users challenged their medication regime on the pragmatic grounds that it caused intolerable side effects. They thus accepted the medical model in principle, but found its associated procedures ineffective. Greta refused medication for seven months because she thought that it was making her feel tired, causing considerable conflict with medical staff. In her view, 'they need the medication, not me'. This criticism resonates with the more general charge that the medical profession colludes with the pharmaceutical industry to systematically underestimate the undesirable side effects of drug treatments (Busfield, 2004). The next quotation illustrates a more conceptual objection to the medical model, based on a distinction between the brain and the mind:

*The thing is with my case I feel let down ... [With] mental conditions, you can treat the chemicals in the brain ... But with psychological, it is a way of thinking. It doesn't matter how much medication you get, if the person is in that frame of mind. It is a way*



*of thinking, so you've got to change the thinking.* (Noel, service user)

The quotation challenges the medical orthodoxy which views mind as an epiphenomenon of the brain, carving out an independent arena for psychological interventions. This distinction can be understood in terms of an analogy to computer hardware and software disfunctions. The quotation nicely illustrates the unexamined metaphysical conundrums which underlay the pragmatics of intervention.

### **The Criminogenic Perspective**

The medical model views the crimes of mentally disordered offenders as caused by their illness. The criminogenic perspective, in contrast, assumes that offending is caused by a direct personal propensity which may co-exist with mental disorder.

*We're looking to not only treat the mental illness, but to also tackle the offending behaviour as well. And they work their way through the system from admission to rehabilitation, and then, hopefully, discharge.* (Francesca, nurse ward manager)

Nurses, particularly frontline carers, were most likely to adopt this approach. Doctors were accountable to the Home Office for service user safety and security, but delegated day-to-day risk management to nursing staff who had the greatest direct professional interest in managing safety. This process can be understood in terms of the concept of 'degradation', the hiving off of less culturally valued activities to lower status professions (Abbott, 1988, p. 118). The next quotation links the risk of future offending to coping ability which, the respondent argues, the medical model does not address:

*Because [of] the predominance of the medical model of offending behaviour... there's a big assumption that you're actually gonna impact on that person's future offending. In reality, what happens is, we send patients out based on that model. There's no assessment for coping ... I understand that the medical model predominantly treats non-criminogenically, which we should do first and foremost.* (Nicholas, senior nurse)

As noted above, senior non-medical staff members often nuanced critiques of the primacy of the medical model whilst simultaneously affirming it. Although not apparent in the quotations, Nicholas was considerably more critical of the Unit regime than Norman, quoted above. Nicholas had a primarily clinical role, whilst Norman's role was mainly managerial. Possibly, the requirement to accept corporate responsibility for the functioning of the Unit tempered Norman's criticism of the prevailing medical model. Frontline staff sometimes expressed forthright challenges to what they saw as an overly therapeutic approach to managing patients:

*In my view they [the staff] are too relaxed, because, at the end of the day ... you are dealing with forensic patients. But ... I think a lot of the staff sort of forget that.* (Paula, health care assistant)

Paula had recently been moved to an annexe at the neighbouring generic psychiatric hospital due to a lack of space in the main building. Patients, thinking ecologically, as discussed below, reported that the atmosphere was more relaxed in this annexe than in the main Unit site. Similarly, Nicholas, the senior nurse quoted above, criticised occupational therapy for its *'tin of beans mentality'*. In his view, some occupational therapists sent service users out to shop without considering the risks involved. He categorised nurses as *'hawks and doves'*. The former, according to him, behaved like prison officers, whilst the latter were:

*very much in a therapeutic community mode ... They are so loose and so liberal that they've lost the plot.* (Norman, nurse manager)

In rebuttal, members of other professional groups criticised nurses for viewing service users primarily as offenders:

*All your [nurses'] past experience has been around monitoring risk within a secure environment.* (Luke, occupational therapist)

Luke believed that this approach created *'intrinsic iatrogenic factors'*, risks to service user progress towards rehabilitation arising from treating them as inherently dangerous. Some nurses responded to the tension between giving primacy to criminogenic and mental health issues by bracketing out the former:

*We are not treating behaviour. We are treating mental illness. If a person is stable and he still goes and offends, that is a behaviour. Behaviour is untreatable. We treat mental illness ... We have to manage their behaviour, bearing in mind that behaviour is not treatable.* (Laurent, primary nurse)

This respondent drew a complex inference from the combination of criminogenicity and mental disorder, viewed as separate entities. Offending behaviour combined with the absence of mental disorder provides evidence of an untreatable behavioural disorder. In contrast, by implication, the combination of mental disorder plus offending behaviour cannot be interpreted because the offending might be caused by the mental disorder, and so treatable. Similarly, an occupational therapist excluded personality disorder and illicit substance use as not *'genuine'* mental illness:

*I think we work well with people with personality traits. But when it comes down to disorders, it's very difficult to help them in this kind of environment ... There are specialised units for them. It's not a clinical*

*interest of mine ... I prefer working with people who are genuinely mentally ill ... Not habitual criminals who are classified as mentally ill because of PD [personality disorder] or habitually out of their heads on cocaine. (Luke, occupational therapist)*

Such accounts divorce mental illness from behaviour, seen as respectively within and outside the scope of forensic mental health services, suggesting that they somehow exist as separate entities. The distinction drawn between personality 'traits' and 'disorders' portrays another clinical boundary, raising the question of when a trait becomes a disorder.

Service users and providers were not asked directly about offending histories. Nevertheless, respondents did initiate some discussions, often involving denials of criminogenicity. Such denials, whether justified or not, undermined attempts to deal with presumed criminogenicity:

*The work that I have done with Daniel has been really against the background of ... him pleading his innocence ... Because of his continuous and insistent whatever, it is very, very hard. (Haris, social worker)*

Daniel saw himself as safe and ready to discharge:

*I want to be free. I have been doing self-catering for three years. I'm not a danger to myself. I'm not a danger to anyone. I'm not getting my accommodation. (Daniel, service user)*

Daniel's calibration of his risk status in terms of his daily living skills resonates with the criticism of the perceived occupational therapy 'tin of beans' attitude to criminogenicity, but was structured into the progression towards self-care around which Unit careers were organised. Service users could meet the requirements of this system but remain trapped at the point of release because staff felt that their criminogenicity had not been tackled. Staff indicated that they were collaborating in order to manage this impasse.

*So what Haris [social worker], Sean [community psychiatric nurse] and I have done is in terms of thinking about Daniel being discharged, we, I'm determined to do a joint risk assessment ... In a way it is an indirect piece of work ... You actually needed to put in some kind of behind the scenes time in order to be able to meet and compare notes about that [the risk] and to gather information. (Timothy, Psychologist)*

The intractability of this problem may have stimulated the development of a fragile, informal island of interdisciplinary collaboration.

### **The Existential Perspective**

As with the medical and criminogenic approaches, the existential perspective located 'the problem' clearly in enduring attributes of the individual (as in Dostoevsky's *Crime and Punishment*). However, rather than stopping the explanatory chain with a first cause framed in terms of disease or criminal propensities, this approach further explained these tendencies as themselves resulting from the person's response to traumatic childhood experiences:

*Diagnosis was not clear. My view would be that he had a severe borderline personality disorder ... He'd been in contact with services since [pre-school], and he was [a teenager] when he was admitted here. He had a long history of being sexually abused. He himself had abused children, and he'd taken drugs. He'd also had these episodes of psychosis. He had assaulted staff on the Unit ... And so I worked with him on the sexual abuse, on his own abuse as well as his own tendency to abuse others ... which I think was quite successful.*  
(Pamela, psychologist)

In this account, the service user's medical problems and offending behaviour are linked to his personal response to his biographical past. This approach could give rise to conflict with the medical profession:

*I think it's always been too medically centred you know. The medical profession, they are the ones that make the decisions ... I mean the registrars and the senior house officers will come in and make decisions that are, you think, 'Hold on, you've known someone for six minutes. We have been working with them for a year. We might have a different idea'.* (Pamela, Psychologist)

The quotation illustrates some less obvious differences between medical and personal biographical approaches. Doctors, whose views prevailed according to the above respondent, may consider that they can make sound decisions providing they obtain sufficient information to diagnose an illness. The psychologist saw herself as engaging with the existential world of the offender, a time-consuming business. In consequence, service users were offered two distinctive implicit interpretations of 'insight'. The following patient account combines these approaches as he defines himself as ill (paranoid) but also links his problems to his personal biography:

*If I've got insight ... about being ill, I can do something about it. I can talk to someone about it ... There's a fella in here, and he come in the other [day] about lunchtime, and ... I was a bit paranoid ... And, like, I don't know them, but I know they come from [home town]. And that's where the trouble started. So what I've done, I just got me paranoia, I just pulled myself, pulled my socks up, and said like, 'There's nothing wrong. It's just somebody who comes from [home town]' ... That's*

*better than I was before I started going down the wrong way.* (William, service user)

This perspective offers a more reflective view of mental illness dynamics than is allowed for in the pure medical model. The complex of mental disorder and offending, bracketed together, arises from damaging biographical choices which can be modified, setting the person's life course in a new direction.

### **Ecological Perspectives**

Ecological accounts attribute service user problems to their adaptation to present circumstances rather than solely to their personal dispositions. This contrast is sharply drawn in the next quotation:

*Staff could help me in this place a lot more. When someone in my family dies, they could sit down and talk to me about it ... So, when the doctor dives into the past and says, 'Explain your past, explain this, then explain your childhood and your adult life', it's a waste of time, because the only thing that is important is the here-and-now, the present.* (Noel, service user)

Noel's view can be contrasted with that of Pamela, the psychologist cited above, who emphasised the damaging effects of past traumatic experiences. As illustrated below, staff who viewed service users problems in this way tended to focus on frustrations associated with the Unit, whilst service users were also concerned about their wider lives. Some staff members identified iatrogenic effects of confinement on service users:

*I think the environment of medium security can influence how our patients behave because there are so many barriers here, and structures that some personalities can't cope with it. They fight against this system. And rather than relaxing down and going with the system... they can't cope and ... they find themselves going back deeper and deeper into the system here... It only confines and spirals a patient out to be on a ward like [Intensive Treatment Unit] for too long.* (Patrick, social worker)

This account identifies a risk of 'spirals' of positive feedback, with service user rebellion provoking a more controlling institutional response which stimulates further rebellion. The service user quoted below also recognised this vicious circle which he discusses in terms of how to escape it:

*Well, I suppose I played the game the right way, you know ... That's to keep quiet and wait, you know, to get better.* (Tom, service user)

Tom felt that accepting the system would, through the passage of time, somehow be therapeutic. At the same time, he saw compliance as a 'game', a tactical resource yielding in eventual release. This perspective raises questions about the ecological validity of the treatment process, discussed below in connection with an apparently model service user:

*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. (Leticia, primary nurse)*

This account suggests that an environment which rewards compliance may simply conceal criminogenicity. Conversely, the next quotation illustrates how apparent criminogenicity could be accounted for tactically, as a means of achieving a desired goal in the present environment:

*He [Boyd] 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. (Isabel, health care assistant)*

Boyd's tactic may have succeeded because the consultant viewed his behaviour as symptomatic of illness, and prescribed a home visit. When asked why the consultant had taken this decision, which Isabel regarded as 'complete madness', she cited the reason given in Boyd's medical notes, namely 'to allay his [Boyd's] anxiety'. Informal discussions with nursing staff revealed divided views about whether Boyd, who had spent many years in secure institutions, posed any current risk to the public.

Even substance misuse, discussed further below, could be located in the current social ecology. The respondent quoted below saw attempts to get round the ban on bringing drugs and alcohol into the Unit as elements in a power struggle:

*Their illness is not clear-cut, and then they get into what we call 'jailing behaviour' which is about manipulation. It's about subversion. So that's about splitting the staff, and start bringing drugs and alcohol into the units. (Norman, nurse manager)*

This analysis depicts such behaviour as challenging the social order of the organisation, rather than as driven solely by personal addiction. Such accounts explain service user behaviour in terms of actors' reasons rather than causal processes such as mental disorder.

Staff rarely mentioned service users' personal lives, about which their knowledge was limited. The latter were more likely to define their problems in terms of significant relationships and their future prospects:

*I was told B was dead. And that made me upset, and I was crying for the whole day. Then, the next day, I got up, I wanted to go to the shops to get hold of my, you know, washing my clothes and stuff, and just getting over it, you know, and they [Unit staff] wouldn't let me go out. They made my life hard ... This member of staff, he actually called the [Emergency Response Team], and they are there specifically to inject you with something to knock you out. Now, I didn't want to be knocked out, not after my friend died, and I didn't want to go through any grief. So, I just lost my temper and I smashed up [the ward]. (Noel, service user)*

This service user explained his response as an escalation resulting from staff insensitivity to his life crisis. The staff response is portrayed as controlling through force, presumably because they viewed his initial reaction as a sign of mental disorder and/or criminogenicity. From an ecological perspective, the ability to cope with their future environment outside the Unit becomes a central issue affecting rehabilitation:

*I think, I am a bit biased. I think we have got quite a key role in it ... As an OT, you look at function and people's independence. So we try and help people to develop skills so they can be more independent, so they can move on, and move through the Unit, and move out into the community. (Olivia, occupational therapist)*

The notion of 'bias' suggests that this respondent saw her professional arena as under attack. Her defence against the 'tin of beans' criticism of occupational therapy, cited above, associates movement through the Unit with eventual release, without which internal progression would lose most of its purpose. Linking movement through the Unit to survival in the community strengthened the case for occupational therapy.

### **Substance Misuse**

A few respondents gave aetiological primacy to the drugs culture prevalent in the local environment which most service users returned to. Framed in this way rather than in terms of criminogenicity resulting from addiction, such accounts offer a specific kind of ecological explanation. According to the nurse quoted below, participation in this culture could magnify the impact of other marginal risk factors which, on their own, might not have tipped the service user into mental disorder and offending:

*These patients have been bordering from adolescence on certain behaviour, but they have never been treated early in the onset of the illness. And, I think, coupled with drug usage, I think about 90% of the*

*patients that come to our unit have used drugs at some time ... Then, as a result, you find you have guys drifting further and further into this kind of behaving and drug culture, and getting involved in crime. And I think that's where it all starts. And after being in an institution for say two years, coming out, not being able to find a job, or, probably, not wanting to have a job because of the whole drug culture. (Kunle, charge nurse)*

As with so many of the non-medical professionals quoted, Kunle incorporated his alternative aetiology within a framework which acknowledged the primacy of the medical model, with borderline mental disorder seen as the starting point for full-blown illness plus offending exacerbated by institutionalisation and exclusion from the mainstream economy. In this account, illicit substance usage plays the role of catalyst rather than prime cause.

Because the Unit was not organised to deal with illicit substance use or alcohol misuse, emphasis on its importance challenged the established social order of the organisation:

*Drugs and alcohol are a huge issue, and I have been fighting for years in everywhere that I have worked ... People are just not addressing it at a proper, real level, where they need the funding. They need the specialists to come in. (Sylvia, psychologist)*

This criticism of organisational risk selection was linked to a call for additional resources to manage problems which none of the staff groups was equipped to deal with.

## **DISCUSSION**

The findings of the present study are based on data obtained in one medium/low secure Unit with its own organisational attributes, history, culture and local environment. The methodology is affected by the usual limitations of qualitative research. The views expressed illustrate rather than represent possible positions. Interviews offer public views, often idealised, although comparisons of perspective can reveal underlying organisational dynamics. The researchers were able to complement formal interview data with a wealth of information obtained through informal discussion and observation. The analysis depends upon the authors' interpretations of the quoted data which were discussed with Unit staff and service users.

Within the limits of small-scale qualitative research, the data document linkages between problem definitions and professional/service user grouping, as outlined at the beginning of the data analysis section. Problems were divided in various ways, for example between 'traits' and 'disorders' and between 'illness' and 'behaviour'. Service users made sense of their situation



in this context of differing professional accounts of their problems and care. Their perspectives often differed from those of the professionals who mostly saw enduring intractable individual deficiencies. Some service users did not regard themselves as offenders. Some emphasised the influence of their present personal life, particularly their relationships with significant others. Even when service users ostensibly conformed to the medical model, their motives might be suspected. Service users were the only party exposed to, and required to make sense of, the full spread of disciplinary perspectives. Overall, professions constructed service user problems to fit with their own disciplinary understandings. Two significant issues, illicit drug use and personal circumstances may have been neglected because they did not resonate with available disciplines.

In the Introduction, four ideal typical models of crossdisciplinary relationships were discussed: monoprofessional self-organisation linked to restricted cross-professional communication; hermeneutic outreach; the evolution of interprofessional subsystems; and transdisciplinarity. This highly abstract debate needs to be informed by engagement with concrete illustrative cases. Much of the data obtained for the present study fits with the first model, that of monoprofessional autopoiesis. Little evidence was found of communicative rationality, i.e. recognition and valuing of disciplinary differences of perspective combined with synthesis in specific cases. Professional accounts of service user problems occasionally matched the transdisciplinary and interprofessional island ideal types of crossdisciplinary merger.

Professionals frequently viewed the same event in terms of their own frames of reference without realising how it might be understood differently. Nurses often represented other professions as blind to security issues, whilst occupational therapists might emphasise the iatrogenic causes of behaviours which nurses classed as criminogenic. Allowing a service user who had threatened to commit serious crimes to make a home visit could be dismissed as '*madness*' by a security-conscious nurse, but be judged sensible by a doctor as a therapeutic response to a medical crisis. The service user in question offered a third perspective, representing himself as manipulating the doctor to agree to a home visit by feigning illness. Psychologists criticised doctors for making over-hasty decisions about service users. However, doctors may have considered a relatively short amount of time spent with a patient sufficient to make a diagnosis whilst psychologists were considering the amount of time required to understand a personal biography. 'Insight' could mean recognition of their illness to doctors and existential understanding of their personal biography to psychologists.

Organisational contexts to which participants bring different frames of reference without appreciating those of others are likely to generate many equivocal situations (Harré, 1993), as epitomised in the genre of classical farce. A similar pattern of professional self-organisation combined with disfunctional communication has been identified in a general hospital setting

(Rayner, 1986). Rayner distinguished entrepreneurial, bureaucratic and practical approaches to the risk management of radiological substances, adopted by doctors, administrators and low status front-line workers respectively. This difference generated mutual accusations between these groups, for example of bureaucratic rigidity and risk blindness.

Although the present study illustrates barriers to hermeneutic understanding between professions, it does not follow that such barriers can never be overcome. Such general pessimism is not warranted by a specific qualitative study, although the findings do suggest that organisations will readily revert to a ground state of crossdisciplinary incomprehension which needs to be actively countered. Going beyond the study data, it is possible to speculate about the conditions which may promote hermeneutic, subsystem or transdisciplinary communication between professions. These conditions may involve generic organisational factors or features of the form of human service in question. In terms of organisational structure, the degree of conflict between the professions illustrated above might be associated with its troubled organisational history (Heyman *et al.*, 2004).

The extent of power differences, both between doctors and other professions and between staff and forensic mental health service users, a doubly stigmatised group, may impede the give and take required for disciplinary synthesis. Habermas (1984) emphasised that communicative rationality can only be achieved under conditions of roughly equal power. Moreover, regression and degradation, discussed above in relation to medicine, may undermine the social power which fuels them. Limited observation of multiprofessional case conferences suggested that these were medically dominated. Regression and degradation may make a profession less able to relate to other disciplines, and more remote from crucial issues, such as security in the case of forensic mental health care. The data document the mostly one way direction of influence between medicine and other disciplines, and between the professions and service users. Unless these power differences are addressed, genuinely multilateral communication between the participants in forensic mental health care may be unachievable. Future research could focus on both the meaning to service users, and ethnographic observation of, crossprofessional working.

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