



City Research Online

City, University of London Institutional Repository

Citation: Reynolds, L. M. (2010). Risk and the regulation of communication in relation to service users and providers experiences of forensic mental health care. (Unpublished Doctoral thesis, City University London)

This is the accepted version of the paper.

This version of the publication may differ from the final published version.

Permanent repository link: <https://openaccess.city.ac.uk/id/eprint/7783/>

Link to published version:

Copyright: City Research Online aims to make research outputs of City, University of London available to a wider audience. Copyright and Moral Rights remain with the author(s) and/or copyright holders. URLs from City Research Online may be freely distributed and linked to.

Reuse: Copies of full items can be used for personal research or study, educational, or not-for-profit purposes without prior permission or charge. Provided that the authors, title and full bibliographic details are credited, a hyperlink and/or URL is given for the original metadata page and the content is not changed in any way.

City Research Online:

<http://openaccess.city.ac.uk/>

publications@city.ac.uk

**Risk and the regulation of
communication in relation to
service users' and providers'
experiences of forensic mental
health care**

Volume 1

Lisa Marie Reynolds

PhD

City University London

School of Community and Health Sciences

*Department of Mental Health and Learning
Disability and the Department of
Interdisciplinary and Professional Practice.*

September 2010

Contents

Contents	2
Acknowledgements	8
Declaration	9
Abstract	10
Glossary	11
Chapter One	12
Introduction	12
1.1 Introduction	12
1.2 What the thesis is about	12
1.3 The research context	14
1.4 Research problem	15
1.5 Research aims	15
1.6 Methodology and methods	15
1.7 Background to the study	19
1.7.1 <i>Forensic mental health care</i>	19
1.7.2 <i>The structure of forensic mental health services within the UK</i>	20
1.7.3 <i>Medium secure mental health services</i>	21
1.7.4 <i>The development and function of medium secure services</i>	21
1.7.5 <i>Statistical descriptors of medium secure services</i>	22
1.8 Problems with the provision of forensic mental health care	23
1.8.1 <i>Problems with risk assessment</i>	23
1.8.2 <i>Failure and inquiry</i>	24
1.8.3 <i>Problems with service user involvement in forensic mental health services</i>	27
1.9 An international perspective	29
1.10 Structure of the thesis	29
Chapter 2	30
Literature review: Part one, a review of empirical research	30
2.1 Introduction	30
2.2 A review of empirical research on forensic mental health care	31
2.2.1 <i>Service provider and users' experiences of forensic mental health services</i>	34
2.2.2 <i>Service providers' experiences: the balance between safety and autonomy</i>	35

2.2.3 <i>Relationships between service providers and multidisciplinary team working</i>	39
2.2.4 <i>Relationships between service users and providers</i>	41
2.3 Risk as a social status	45
2.3.1 <i>Interpretations of risk</i>	45
2.4 The regulation of communication within organisations	51
2.4.1 <i>The regulation of communication</i>	51
2.4.2 <i>Silencing</i>	52
2.4.3 <i>Gossip</i>	56
2.4.4 <i>Limitations of the studies reviewed</i>	58
2.5 Summary and conclusions	59
Chapter 3	61
Literature review: Part two, a review of theory	61
3.1 Introduction	61
3.2 Symbolic interactionism	61
3.2.1 <i>An overview of symbolic interactionism</i>	62
3.2.2 <i>Central principles of symbolic interactionism</i>	62
3.2.3 <i>The self</i>	64
3.2.4 <i>Society</i>	65
3.2.5 <i>Symbols</i>	66
3.2.6 <i>Organisations</i>	67
3.3 Risk concepts and theories	69
3.3.1 <i>Risk in a forensic mental health care context</i>	70
3.3.2 <i>Definitions of risk</i>	71
3.3.3 <i>Risk theories</i>	72
3.3.4 <i>Positivist approaches to risk</i>	73
3.3.5 <i>Psychological approaches to risk.</i>	76
3.3.6 <i>Technical and rational approaches to risk regulation in health care</i>	78
3.3.7 <i>Problems with probabilistic approaches to risk</i>	79
3.3.8 <i>Interpretive approaches to risk</i>	80
3.3.9 <i>Cultural theory</i>	81
3.3.10 <i>Governmentality</i>	84
3.3.11 <i>Risk systems theory</i>	87
3.4 Summary and conclusions	91

Chapter 4	93
Methodology	93
4.1 Introduction	93
4.2 Aims of the study	93
4.3 Research methodology	94
4.3.1 <i>The epistemology of grounded theory</i>	95
4.3.2 <i>Grounded theory</i>	96
4.4 Research design	98
4.4.1 <i>Advisory group</i>	99
4.4.2 <i>Access to the research site</i>	99
4.4.3 <i>The research setting</i>	100
4.4.4 <i>A description of the research setting using observational data</i>	100
4.4.5 <i>The clinical pathways within the forensic service</i>	103
4.4.6 <i>The managerial structure of the forensic service</i>	104
4.4.7 <i>Clinical structure of the forensic service</i>	104
4.4.8 <i>Ward environments</i>	105
4.5 <i>The characteristics of service user and provider research participants</i>	106
4.6 <i>Events which affected the conditions within the research site</i>	107
4.7 <i>Sampling strategy</i>	108
4.8 <i>Sampling for data collection by formal interview</i>	109
4.8.1 <i>Sampling for the observation of activities within the forensic service</i>	110
4.8.2 <i>Exclusion criteria</i>	110
4.8.3 <i>Limitations in sampling</i>	111
4.8.4 <i>Problems with access for observation</i>	112
4.9 <i>Methods of data collection</i>	112
4.9.1 <i>Formal interviews</i>	112
4.9.2 <i>Data collection by participant observation</i>	115
4.9.3 <i>Informal interviews undertaken during participant observation</i>	116
4.9.4 <i>Recording data: the use of field notes</i>	117
4.9.5 <i>The researcher as participant observer: roles assumed and assigned</i>	119
4.9.6 <i>Role assignment</i>	120
4.9.7 <i>The researcher's relationship to the research site</i>	121
4.9.8 <i>Feedback to research participants and leaving the field</i>	123
4.9.9 <i>Limitations to observational work</i>	124

4.9.10 <i>Case note review</i>	125
4.9.11 <i>Focus groups</i>	125
4.10 Data quality	126
4.10.1 <i>Credibility</i>	126
4.10.2 <i>Transferability</i>	127
4.11 Analytic procedures: data analysis	129
4.11.1 <i>Open, axial and selective coding</i>	130
4.11.2 <i>Selective coding</i>	131
4.12 Ethical issues	132
4.12.1 <i>Risk to the researcher</i>	133
4.12.2 <i>Exploitation</i>	134
4.12.3 <i>Anonymity and confidentiality</i>	136
4.12.4 <i>Anonymity and publication</i>	137
4.12.5 <i>Limitations to agreements of confidentiality</i>	138
4.12.6 <i>Consent, anticipated and emergent issues</i>	138
4.12.7 <i>Consent: participant observation</i>	139
4.12.8 <i>Consent: emergent issues</i>	141
4.13 Summary	142
Chapter 5	144
Results: the reflections of the researcher	144
5.1 Introduction	144
5.2 <i>Background to working in forensic mental health care</i>	144
5.2 <i>Entering the field of study</i>	146
5.3 <i>Social position in relation to research participants</i>	147
5.4 <i>Relationships with service providers</i>	148
5.5 <i>Relationship with service users</i>	151
5.6 <i>Ethnicity and relationship with research participants</i>	152
5.7 <i>How the researcher managed tensions within her role of participant observer</i>	152
5.8 Summary	153
Chapter 6	154
Results: The regulation of communication by service users	154
6.1 Introduction	154
6.2 Problems with service users being heard by the organisation	155
6.3 Playing the silencing game	163

6.3.1	<i>Game playing as a dynamic process</i>	178
6.3.2	<i>Problems encountered by service users when playing the game</i>	183
6.3.3	<i>Problems for service providers with playing the game and assessing risk</i>	188
6.4	Conclusions	190
Chapter 7		193
Results: The regulation of communication by service providers		193
7.1	Introduction	193
7.2	Problems with information sharing by service providers	197
7.3	The avoidance of blame	202
7.4	Silencing challenges to the social order	218
7.4.1	<i>Informal group pressure to regulate communication</i>	221
7.4.2	<i>Advice for the researcher as an outsider to self-censor</i>	229
7.5	Medical dominance and multidisciplinary team power relationships.	231
7.6	Summary	244
Chapter 8		247
Discussion		247
8.1	Introduction	247
Diagram 2:	The regulation of communication and the management of risk status	249
8.2.	The emergence of the regulation of communication.	250
8.2.1	<i>Self-report</i>	250
8.2.2	<i>Observation</i>	251
8.2.3	<i>Report of observation by other research participants</i>	252
8.2.4	The non-occurrence of focus groups	253
8.3	The regulation of communication in attempted management of regulate risk status	254
8.3.1	<i>The regulation of communication within self-forming groups.</i>	257
8.3.2	<i>Difficulties with exploring the regulation of communication</i>	260
8.3.3	<i>The management of own risk status</i>	262
8.3.4	<i>The situational nature of risk status</i>	262
8.3.5	<i>Ways in which risk status was managed, by service user research participants</i>	263
8.3.6	<i>Service users' risk status in the context of service provider assessment</i>	264
8.3.7	<i>Service users' risk status in the context of their peers</i>	265
8.3.8	<i>Service providers' management of risk status: ward based staff</i>	267
8.3.9	<i>Service providers' management of risk status: unit managers</i>	268

8.4 Internal influences on the regulation of communication to manage risk status: self-forming groups	269
8.4.1 <i>Self-forming groups as 'family'</i>	271
8.5 External influences on the regulation of communication to try to manage risk status	274
8.5.1 <i>Wider, indirect influences to regulate communication to try to manage risk status: professional pressures</i>	279
8.6 Summary and conclusions	281
8.6.1 <i>Summary of conclusions</i>	283
8.7 Recommendations for practice	284
8.7.1 <i>Recommendation 1: Organisational systems of communication</i>	284
8.7.2 <i>Recommendation 2: Risk status</i>	285
8.7.3 <i>Recommendation 3: Managerial practices</i>	286
8.8 Strengths and weaknesses of the study	286
8.8.1 <i>Former insider role of the researcher</i>	286
8.8.2 <i>Ethical considerations</i>	288
8.8.3 <i>Single site case study</i>	289
8.8.4 <i>Theoretical framework used</i>	289
8.9 Future directions	290
8.9.1 <i>Dissemination of the research findings</i>	290
8.9.2 <i>Analysis of data</i>	290
8.9.3 <i>New research</i>	291

List of Tables and Illustrations

Diagram 1: The stages of data collection and analysis	132
Diagram 2: The regulation of communication and the management of risk status	251
Table 1: Grounded theory terminology	19
Table 2: Terms used to search the literature	34

Acknowledgements

There are so many people and organisations to whom I am indebted. Most importantly I would like to thank the forensic mental health service users, and providers without whom this study would not have been possible.

I owe a huge debt of gratitude to my supervisors; to Prof. Bob Heyman whose commitment to the grounded theory methodology, critical eye and immense patience over the past five years made this thesis possible; to Prof. Della Freeth who helped me to focus, saved me from moments of despair and gave the courage to submit; and also to Dr Kathryn Waddington for her support with writing up.

I would also like to thank my colleagues at City University; Dr Peter Phillips, Dr Julia Jones, Prof. Anthony Pryce, Soo Moore, Dr Paul Godin, John Hutton, Jacqueline Davies, Prof. Dinah Gould, and Dr Eamonn McKeown for their support, advice and for keeping me motivated. I must also thank Emily Shave who helped me with the formatting and presentation of this thesis.

I acknowledge the financial support provided by the Health Foundation and the research and leadership programme provided by the Health Care Consortium.

Finally I must express my gratitude to my family; my husband Justin for being so patient and understanding; my parents Rosemary and Colin for their support and encouragement; and to Courtney for waking me up every day at 6am and then keeping me company whilst I was writing.

Declaration

I grant powers of discretion to the University Librarian to allow this thesis to be copied in whole or in part without further reference to the author. This permission covers only single copied made for study purposes, subject to normal conditions of acknowledgement.

Abstract

This thesis presents a qualitative study of service users' and providers' experiences of one UK inner city medium secure forensic mental health service. The study focussed on the processes through which service users and providers attempted to manage their risk status.

Aims

The study had three main aims:

1. To develop a greater understanding of the complex formal and informal risk assessment and management processes operating in medium secure forensic mental health services.
2. To investigate the processes through which providers and users of medium secure services attempt to manage risk by balancing safety with the promotion of service user autonomy.
3. To generate recommendations derived from the study findings for the development of forensic mental health services.

Methodology and methods

A qualitative grounded theory methodology was used to explore forensic mental health care from the perspectives of service users and providers. Data were collected through lightly structured interviews and participant observation. Participant observation occurred over a period of eighteen months. Activities that took place within the service were observed and spontaneous informal conversations between the researcher and participants recorded. A theoretical sampling approach was adopted. Design, data collection and analysis were done in cycles so that the direction of inquiry could be grounded in participants' concerns. Eventually, data collection and analysis were organised around the core category of the regulation of communication.

Findings

The regulation of communication was analysed in relation to three other important categories: the management of own risk status; the dynamics of self-forming groups; and external role expectations. It is hypothesized that the regulation of communication provided a means of attempting to meet competing role expectations and thus manage risk status.

Conclusions

The study provides an insight into how service users and providers situated within a complex and conflicted system may attempt to manage their risk status through regulating their communication. This strategy enables service users and providers to attempt to achieve the highly problematic mission of the forensic mental health service; to provide mental health care and public protection. However, organisational learning and risk management may be hampered by the regulation of communication as information regarding clinical and organisational risks may be silenced within official organisational systems. Furthermore underlying problems may remain unresolved for users and providers who feel unable to express dissent.

Glossary

Atlas.ti	Qualitative analysis data software
BME	Black and Minority Ethnic (people). The term BME refers to people from the following census categories: White Irish, white other (including white asylum seekers and refugees and Gypsies and Travellers), mixed (white & black Caribbean, white & black African, white & Asian, any other mixed background), Asian or Asian British (Indian, Pakistani, Bangladeshi, any other Asian background), black or black British (Caribbean, African or any other black background), Chinese, and any other ethnic group.
HASCAS	Health and Social Care Advisory Service: an independent organisation that undertakes evidence based service reviews and inquiries within mental health and older people's services in health and social care.
HCA	Health Care Assistant: an unqualified member of the nursing team
L REC	Local Research Ethics Committee which forms part of the National Research Ethics Service for the NHS (NRES).
MDT	Multi Disciplinary Team: an umbrella term used to describe how professionals from different disciplinary backgrounds work together to provide health care.
MSU	Medium Secure Unit: secure services provided for offenders with mental health problems, which are situated within a spectrum of care that is provided under conditions ranging from high to low security. The level of security is defined by the specifications outlined by the Department of Health in their best practice guidance for adult medium secure services (DH 2007)
NHS	National Health Service
Mental Health Trust	A part of the NHS which manages and provides specialist health and social care for people with mental health problems both within hospital and community settings.
OT	Occupational Therapist
RMO	Responsible Medical Officer: the psychiatrist who is responsible for all aspects of the medical care of a patient detained under the Mental Health Act 1983. The Mental Health Act states that only an RMO can bar the discharge of a detained patient and authorise consent to treatment and leave from hospital.
SPR	Specialist Registrar: a doctor in the advanced stages of training to become a consultant.

Chapter One

Introduction

We could have kept it contained.

We could have kept it to ourselves,

with no public prying eyes

and some hope of salvation.

It would have been better.

It would have been quieter.

The knowledge of damnation,

the stench of failure....

(Joolz 1990: In the family)

1.1 Introduction

This chapter provides an overview of the thesis. The research problem which the study sought to address is outlined together with the methodology and methods used. An overview of forensic mental health care is provided, which includes a definition of forensic mental health, statistical descriptors of forensic services and a historical background to service development. Problems encountered by providers and users of forensic mental health services are also explored. The problems discussed are those which emerged strongly from the review of the literature and are associated with risk assessment, public inquiries and service user involvement. Lastly the chapter provides an outline of the thesis structure and content.

1.2 What the thesis is about

This thesis is about how users and providers experienced forensic mental health care. The thesis argues that forensic mental health service providers and users regulate their communications in an attempt to manage their risk status by satisfying competing role expectations. As described by Joolz in the poem above, information relating to failure that is thought to be potentially damaging to individuals or groups of people, may be

kept in the family; known only to members of self-forming groups within the organisation.

Data analysis has been undertaken from a symbolic interactionist perspective. For the purpose of this thesis riskiness is understood to be a social status of individual patients. This status is constructed through the inter-subjective interpretations and interactions of service users and providers within the organisation in the context of wider societal interpretive activity. Furthermore in this thesis the regulation of communication is defined as a means to affect that interpretation through the suppression, inflection, or modification of the communication of information that is perceived by the sender to present a threat to self, social groups or organisational reputation. Therefore the regulation of communication resonates with the social power and role performance of both staff and service users.

The regulation of communication will be considered at an organisational as well as an individual level. It will be argued that this process can impact negatively on the experiences of service users as well as on the organisation's ability to respond to risk and failure. Paradoxically, it will be argued, service users and providers interpretations of organisational procedures and decision-making concerning the containment of risk may result in the suppression of the communication of error, which then negatively impacts upon organisational risk management processes.

The present study was situated in an inner city medium secure forensic service. At the time of data collection the organisation, was being suddenly and unexpectedly put under pressure due to intense criticism from the media and external agencies in response to the publication of a damning homicide inquiry report. Thus the study provides an insight into how communication may be regulated in response to external pressures interacting with internal systems and processes.

1.3 The research context

The research problem emerged out of an exploration of the literature which suggests that the provision of forensic mental health care is inherently problematic. Forensic mental health care operates at the margins of the health and criminal justice systems, tasked with providing mental health care whilst at the same time ensuring public safety. Thus, the mission of forensic mental health services is based upon meeting two conflicting goals. At the same time, it is highly politicised, as indicated by media furore concerning rare but horrific cases of stranger attacks by discharged forensic mental health service users. The negotiation of riskiness as a social status becomes problematic due to the requirement of forensic mental health services to provide security alongside therapy. The provision of these conflicting objectives creates an impossible problem if service providers are criticised by systems of inquiry for taking risks. It has been found that service providers experience tensions resulting from their conflicting roles of therapist and safety manager which may impact negatively upon health care provision through an erosion of the therapeutic relationship, polarised staff teams and staff burn out (Mason 2002; Shafer and Peternelji-Taylor 2003; Clarke 1996). However, there is little empirical evidence about how service users and providers experience and manage the core conflicts of forensic mental health care (Mason 2002). The problems of providing safety alongside promoting service users' autonomy may be considered an integral part of forensic mental health care and so the impact on user and provider experiences may be ignored (Jenkins and Coffey 2002; Heyman et al 2004).

National policy directs that the balance between safety and autonomy is achieved through the scientific assessment of risk (DH 2007). However, the process of risk assessment in secure mental health services is also problematic. The ecology of a secure unit is unlikely to reflect that of the local community. Therefore, an individual's response to being in a secure environment may not provide a valid or reliable indicator of behaviour after discharge (Davies et al 2006). Furthermore the risk assessment of service users may depart from scientific approaches to assessment and be dependent on the personal frameworks of individual service providers (Buckingham et al 2008).

1.4 Research problem

The research problem addressed by the study was that of understanding how service users and providers experience and cope with the conflicts inherent within the provision of forensic mental health care through attempting to manage their risk status.

1.5 Research aims

The present study had three main aims which are outlined below. The aims of the study emerged from the review of the literature and centre upon the social aspects of forensic mental health care. The study aimed to:

1. Develop a greater understanding of the complex formal and informal risk assessment and management processes found within a secure forensic mental health service.
2. Investigate the processes through which providers and users of medium secure forensic mental health services balanced safety with promoting service users' autonomy in the process of rehabilitation.
3. Generate recommendations for the development of forensic mental health services.

1.6 Methodology and methods

A grounded theory approach was used to explore service users' and providers' experiences of forensic mental health care in one inner city UK medium secure service. A grounded theory approach was chosen as it enabled the broad area of study identified to be systematically explored from the perspective of service users and providers (Strauss and Corbin 1998). The use of grounded theory enabled issues of concern for the social actors within the field to be identified and examined and therefore new issues where little research had previously been done could be explored. Furthermore the use of grounded theory methodology enabled an alternative approach

to be taken to understanding riskiness within the context of organisational processes. Thus theory was generated which was grounded in the day to day practices of forensic mental health care.

Grounded theory was developed through combining qualitative and quantitative research traditions. In 1967 Glaser and Strauss published their seminal work "The Discovery of Grounded Theory". (Glaser and Strauss 1967). In the development of grounded theory Glaser and Strauss sought to bring together a rigorous approach to mainly qualitative research with the interpretive insights of symbolic interactionism (Dey 1999). Strauss was part of the Chicago school of sociology; he used symbolic interactionism and pragmatist philosophy to inform the development of grounded theory. Glaser's contributions to grounded theory were underpinned by the quantitative research traditions of Columbia University (Strauss and Corbin 1998).

The grounded theory approach used within the present study was developed from the work of Glaser and Strauss by Strauss and Corbin (Strauss and Corbin 1998). The Strauss and Corbin approach to grounded theory maintains many of the original principles of Glaser and Strauss' grounded theory, but draws more heavily on interpretivist and pragmatist theoretical perspectives. Grounded theory offers a methodology, providing a framework which links the theory of symbolic interactionism with research methods, including those of interview and observation (see section 4.3). In the present study the use of grounded theory provided an approach to using interview and participant observation methods and also combining them together.

A significant degree of the original grounded theory methodology has been retained within the Strauss and Corbin version, including the language used (e.g.: data, and analysis) which reflect with the quantitative research traditions that still, influence grounded theory. In practice grounded theory is usually applied to qualitative data. The main grounded theory terms are outlined below in Table One, below. The definitions of the terminology used are taken from those provided by Strauss and Corbin (1998).

Table 1. Grounded theory terminology

Term	Description
Theoretical sampling	Sampling based on emergent concepts. The conditions within which phenomena occur are explored as well the properties or dimensions of concepts and categories as they emerge. Design, data collection and analysis are developed iteratively.
Constant comparative method	The systematic comparison of two or more phenomena, concepts or categories.
Open coding	The identification of concepts, and the exploration of their properties and dimensions
Axial coding	The discovery of the relationships between categories and with their subcategories according to their properties and dimensions
Selective coding	The final stage of analysis. Theory is refined, concepts are integrated around one core category, and categories are filled out.
Theoretical saturation	The point at which no new properties, relationships or dimensions emerge during analysis.

The research site chosen was fairly typical of medium secure services within the UK (see Research methodology and methods, chapter 3). However, during the data collection a report of inquiry into a homicide committed by a user of the forensic service studied. The recommendations were highly critical and affected not only the functioning of the forensic service concerned, but also impacted on Home Office policy and the practice of other forensic mental health services across the UK. In consequence, shortly after data collection had commenced the study changed from a study of a fairly typical forensic mental health service to the study of a service under pressure. The impact of this change on the study is discussed in more detail in the methodology and discussion chapters of the thesis. The issue of organisational anonymity was managed with particular care due to the publicity surrounding the incident and the publication of the inquiry report.

The study was designed to form four stages: mapping the organisational context; exploring risk assessment and management processes; obtaining feedback about research findings; and the development of recommendations for practice. However, the stages were not discrete and overlapped one another, with cycles of data collection and analysis occurring simultaneously. Data were collected through interviews and participant observation. Participant observation took place within a range of settings within the in-patient forensic mental health service over a period of eighteen months, and was supplemented with informal interviews. Lightly structured formal interviews were also undertaken with service user and providers in order to explore themes as they emerged from the data. Sampling and access to participants are reviewed in detail in chapter 3, research methodology and methods. The process of data collection was discussed with service users and providers and undertaken in a manner that was sensitive to characteristics of the research site.

Data was analysed alongside data collection using constant comparison techniques. Following a grounded theory approach open, axial and selective coding was then undertaken (Strauss and Corbin 1998). The interpretations of the data could not be discussed with the participants as dissemination of the findings of the study within the research site was prevented by the managers of the service studied. However, data analysis and collection was guided by an advisory group that included forensic mental health service users.

Recommendations for practice were generated. The recommendations made for forensic mental health care include the recognition of riskiness as a social status for both service providers and users of forensic mental health services, the development of more reflective managerial systems and the creation of organisational systems that enable open communication and facilitate critical upward communication to occur from front line staff and service users to high ranking managers within the organisation.

Due to a media furore regarding a homicide committed by a user of the forensic service studied and the concerns of the managers of the service that the findings of the study could impact negatively on the organisation, the dissemination of the research findings to research participants has been delayed. It has been agreed with the gate keepers

of the research site, that the researcher will be given access to the site to disseminate the recommendations and findings of the study to users and providers of the forensic mental health service once this thesis has been completed.

1.7 Background to the study

An overview of forensic mental health care is provided below. Forensic mental health care is defined, and service provision in the UK outlined. The problems faced by forensic mental health services in regards to risk assessment and service user involvement are then briefly discussed in order to indicate the wide ranging implications for forensic mental health care of the research problem identified and explored within the present study.

1.7.1 Forensic mental health care

The containment of people who have offended and are considered not to have the capacity to be responsible for their behaviour is at the heart of forensic mental health care. Indeed attempted control and self-agency are central to the individual's entry, progress and discharge from the forensic mental health services. Forensic mental health services may be broadly defined in terms of providing care for individuals who have been in contact with the criminal justice system and who are also seen as having mental health problems. Thus individuals who were mentally ill at the time that they committed an offence, or who have become mentally unwell whilst detained within the criminal justice system are diverted to forensic mental health services to receive care and treatment. In the wider prison population it has been estimated that up to 90% of prisoners have mental health problems (Singleton et al 1998). The Department of Health describe forensic services as meeting the needs of offenders, or those at risk of offending whilst also safeguarding the public. Thus many forensic mental health services users will have been found guilty of committing a crime (DH 2007). However, when first developed secure forensic mental health services provided care for a broad range of patients, the only commonality being that they were believed to pose a risk to themselves or others. Service users who presented with a level or risk or disruptive

behaviour which could not be contained by generic adult mental health services were often transferred into a forensic unit as the only available long term secure mental health facility (Home Office 1975). Not all service users in the medium secure service studied had committed a crime or had been convicted of committing a crime. However, they were all detained under the Mental Health Act (2007) in secure care. Thus all service user research participants had acquired the same risk status irrespective of their history of offending. Moreover, others remain in prison that also have mental health problems. It may be argued that the two categories are to some extent objects of service organisation rather than two separate entities. Thus the riskiness of individuals may be defined by service structure and provision rather than the intrinsic qualities of the individual. Penrose's law states that there is an inverse relationship between mental health service provision and prison occupancy, that when there are fewer beds available within mental health services, the number of people detained within prison increases (Penrose 1939). The provision of health services is reliant on the dominant political view, as well as research evidence. Thus categorisation of offenders may be more dependent on societal attitudes regarding the management of deviance than the qualities of the individual (Gunn 2000)

1.7.2 The structure of forensic mental health services within the UK

Forensic inpatient services are categorised as high, medium and low secure according to the degree of security provided. However, there is little consistency within the categories of security. Prior to 2007 there were no set standards for medium secure services and so there was great variation in the ways that secure units developed, resulting in differences in security measures and treatment models (DH 2007).

The stratification of forensic mental health services according to the level of security provided creates a staged system of security. Individual medium secure units are stratified and organised according to the degree of security and type of therapy to be provided. Furthermore, sub-specialisms have been developed within forensic mental health services, including long-term and personality disorder services, to address the complex needs of individual service users under the umbrella of forensic services. Mechanisms of risk assessment and diagnosis are employed to sort service users into the levels of security and specialist services. As the level of security increases within forensic services the degree of autonomy and privacy that service users are afforded lessens. Heyman et al (2004) have conceptualised forensic mental health services as functioning as risk escalators, which encourage the service user to progress through

decreasing levels of security towards discharge. The risk escalator model is widely used and evident in national policy and the physical structures of forensic services (DH 2007), although usually without an explicit articulation of its logic. The physical structure and function of the forensic service studied is outlined in chapter 3, research methodology and methods.

1.7.3 Medium secure mental health services

The present study was undertaken within a UK medium secure forensic mental health service. Therefore, to situate the research site within UK forensic mental health services a brief description of medium secure services is provided below.

1.7.4 The development and function of medium secure services

Medium secure forensic mental health services were developed following the recommendations made in the Glancy (Home Office 1974) and Butler (Home Office 1975) reports to provide 1000 to 2000 medium secure beds in the UK. The aim of creating medium secure provision was to alleviate the pressure on high security hospitals and to improve rehabilitation by locating secure services within the community. Users of medium secure forensic services were expected to progress towards discharge within eighteen months (Home Office 1974). Thus it was not envisaged that service users would be detained for any great length of time within medium security, rather that medium secure services would provide an assessment, and rehabilitation step down service. However the throughput of services has been considerably slower than originally expected by both Butler and Glancy (Home Office 1974; Home Office 1975). In 2004 over half of forensic service users were detained in medium secure forensic mental health services for more than five years, with a significant number (18%) held for between ten and twenty years (Rutherford and Duggan 2007). The prolonged detention of service users was reflected in the data collected during the present study. One service provider research participant (Karen) expressed frustration with service users becoming stuck in secure care due to problems with risk assessment (see chapter 6). However, conversely another service provider (Max) participant expressed concerns that therapeutic work was being limited by service users being discharged quickly in order to create beds for new admissions

(see chapter 7) . Furthermore the role of medium secure services has been expanded to include the provision of assessment, support and treatment for victims of crime (DH 2007).

1.7.5 Statistical descriptors of medium secure services

Medium secure forensic services have increased in size and diversity of function over the past ten years, following a policy of moving service users from high secure services to lower levels of security and pressures to transfer users from an increasing prison population (Tilt 2000; Bartlett et al 2007). The number of medium secure beds in England and Wales had reached 3,937 by 2008. In 1998 the population was 2,749 (Rutherford 2010). Data provided by the Sainsbury Centre for Mental Health indicates that forensic mental health services are growing, and becoming more restrictive with increased monitoring of service users in the community (SCMH 2010). Since 2000 there has been a year on year increase in the number of admissions to forensic services, the majority transferred from prison or placed on a restriction order under the Mental Health Act (2007). The most common discharge from forensic services is conditional (32%). In the period 2004 to 2006 there was a 25% increase in people subject to conditional discharge being recalled to hospital (SCMH 2010).

Due to the security measures involved, such as the high staff to user ratio, forensic mental health services are costly. Forensic mental health services are also typically low volume, which combined with a slow throughput of service users, means that they are extremely resource intensive. The average cost per person per year is £165,000 compared with £39,000 in prison (SCMH 2010). In exchange for the resources provided, forensic mental health services are tasked with keeping society safe, as well as providing mental health care. Thus, when incidents occur and members of the public are put at risk mental health services may be heavily criticised. Even when service users are discharged from inpatient forensic mental health care, often the ownership of risk may remain largely with the community services.

1.8 Problems with the provision of forensic mental health care

This section will provide a critical overview of problems associated with the provision of forensic mental health care. Risk assessment, inquiry and service user involvement strongly emerged from a review of the literature as being problematic for forensic mental health service users and providers. The areas of risk assessment, failure and inquiry and user involvement in forensic mental health services are discussed below.

1.8.1 Problems with risk assessment

The stakes are high for forensic mental health services when taking risks positively to promote recovery and integration with the community. Service users may have committed serious crimes or have been involved with high profile criminal cases. Reoffending by individuals discharged from forensic mental health services is relatively low in comparison to the prison population, with 2% committing violent or sexual offences post discharge (Rutherford and Duggan 2007). In comparison 27% of individuals released from prison subsequently committed sexual offences and 46% violent offences (Home Office 2007). However, when problems arise with risk-taking and adverse events occur negative media attention is often attracted that reminds the public that forensic services are taking risks with their safety.

Danger remains at the margins of forensic mental health services, at the junctures of rehabilitation, the step down to lower levels of security and eventually to the community. The initial categorisation of individuals to health or criminal justice systems is problematic with the final disposal to hospital or prison often seeming to be akin to a lottery (Prins 1995). It is at the point of identifying and classifying individuals either for control by exclusion or for control through inclusion in society that one is reminded of the potential dangers hidden in the system. Thus, new conflicts are created by the forensic system's reliance on science based rationality which manifest themselves in their relationships with the mental health and criminal justice systems and the wider community, resulting in a greater reliance on purportedly technical and rational approaches. For example the requirement of such systems for risk categorisation demands the generation of more scientific knowledge regarding the selection criteria for inclusion and exclusion and the threshold of acceptable risk (Rose 2000). Thus, a

driver for actuarial based risk assessment is created, together with an emphasis on risk assessment and categorisation rather than therapeutic and transformative approaches to care. The current move towards payment by results and pressure to meet national standards or principles employed by specialist commissioners may be expected to result in greater transparency and conformity in measures of risk and mental health status across forensic services. However, it is difficult to standardise existing complexes of service provision, particularly whilst also seeking to meet the needs of different populations of service users. Standards for medium secure units have been developed by the Department of Health as well as the Royal College of Psychiatrists (DH 2007; Royal College of Psychiatrists 2007). Fourteen standards have been proposed for medium secure units by the Royal College of Psychiatrists. Of these the first three relate to security, whilst service user involvement is relegated to tenth position (Royal College of Psychiatrists 2007). Thus, security appears to be of great importance to the commissioning process, alongside maintenance of the system with standards set relating to staff training, workforce recruitment and interagency working. Security itself has been abstracted into three forms: physical, procedural and relational. Seemingly, security has been elevated from a basic task to a specialism with its own scientific basis, around which human action is organized to support and maintain the supposedly purposive rational structure of the forensic system. The present thesis will explore the operation of one such system in relation to the interactional processes through which risk status is calibrated.

1.8.2 Failure and inquiry

Failure within mental health services is monitored, and individuals held to account through processes of inquiry. A defensive culture has developed within the NHS since the 1960s following a series of untoward events within public services which eroded public trust in the ability of professionals to self-regulate (Shaw 2010). The NHS uses the inquiry process with the aim of learning from past events that occur throughout the organisation in order to control future risk (DH 2000). Thus, a cycle of incident, inquiry and the employment of new risk management approaches has been established in UK health care services. A range of inquiries occur within the NHS. These include homicide inquiries, National Confidential Inquiries and systems of inspection and monitoring by independent regulators such as the Care Quality Commission and the National Patients Safety Agency. This section will focus primarily on the impact of

independent inquiries into homicide committed by forensic mental health service users as this will provide an insight into the problems faced by clinicians and managers at the research site whilst the study was being undertaken.

Since 1994 mental health services have been required to hold public inquiries into homicides committed by their users. Homicide inquiries seek to investigate serious untoward events so that lessons can be learnt and future harm prevented (Alaszewski and Burgess 2007). Homicide inquiry panels operate a quasi-judicial approach to ascertain the facts surrounding an incident make causal connections between the facts, risks and events and attribute responsibility.

The health care regulatory system is a complex one, with many regulatory services investigating organisational failures, which for forensic services may be further compounded by the involvement of the Home Office in matters of security. Investigations may be triggered by complaints, or data held on local or national data bases about specific trusts or hospitals that are found to deviate from the acceptable range of health care statistics. Such inquiries use a positivist frame to detect failures and so attempt to manage risks more effectively.

....only investigation can diagnose the precise cause of failure.
(Health Care Commission 2008:16)

However, this approach to risk management may also be considered a cultural tool for apportioning blame. Thus rather than managing risk in order to avert future negative incidents, investigations may be viewed as employing risk as a forensic resource to attribute blame and thus affect individuals' risk status (Douglas 1990).

The inquiry process has been criticised by health care professionals who note the negative consequences of public inquiries on health care providers and question whether, without the benefit of hindsight, serious untoward incidents such as homicides might have been prevented (Szmukler 2000). The hindsight bias potentially affects the

outcome of all inquiries, as the views of the panel may be coloured by their knowledge of the untoward incident, with past decisions made being viewed as erroneous based upon the known outcome. The hindsight bias in the context of inquiry is likely to result in an individual being found at fault for not interpreting information as the investigators have, from a post-incident perspective. Often individual service providers are seen to be the cause of the incident, and are treated as scapegoats in order to deflect attention from systemic factors that might have contributed to the incident, and to affirm and strengthen the organisation and the social order within it (Douglas 1990; Szmukler 2000; Butler and Drakeford 2003). Furthermore, holding inquiries into serious untoward incidents such as homicides, and finding an individual to blame, allows uncomfortable feelings of impotence, which often arise when the origins of the dangers or threat encountered cannot be comprehended, to be avoided (Baumann 2003).

The impact of the recommendations of homicide inquiries is variable, with some inquiries, such as that into the murder of Jonathan Zito by Christopher Clunis, greatly affecting national and local policy, whilst others, such as the case of Isabel Schwartz, go largely unnoticed (Butler and Drakeford 2005). Butler and Drakeford (2005) argue that, in order to have an impact on policy, homicides need to be constructed as a scandal. Scandal does not occur due to the event itself but results from its context, for example cruelty inflicted by supposed carers. Thus the thresholds of acceptable risk are dynamic, and are dependent on social context, particularly the implicit moral order. The parameters for the construction and evaluation of risk are culturally as well as scientifically derived (Butler and Drakeford 2005). Inquiries may be viewed as a cultural response to anxiety within society, regarding the dangers presented by mental health service users (Warner 2006). Certain notable inquiries, such as that into the death of Christopher Clunis (Ritchie, Dick and Lingham 1994) have influenced the development of local and national policy. Butler and Drakeford (2003) have noted that degree of influence that an inquiry report has is dependent on the level of scandal and media interest that it generates. Warner (2006) views inquiry reports as active texts that express social power through the process of blaming and protection, thus strengthening the structures within society through the endorsement of the segregation of mental health service users from the wider society. From this perspective, inquiry reports can be considered to create and maintain social order, through constructing social relationships and strengthening social structures, which marginalise forensic mental health service users and providers.

In response to a major inquiry, or series of inquiries, a defensive culture may be developed within mental health care organisations (Passmore and Leung 2002; Warner 2006). An inquiry culture is one of blame with an associated avoidance of decision-making and risk-taking. Individuals acquire a raised awareness that decisions might be viewed differently and individuals blamed if things go wrong. Thus, an under reporting of incidents might also occur as a form of protection against blame and the consequences of blame. Paradoxically underreporting may result in greater risk to the organisation as lessons cannot be learnt and systems adapted to prevent similar errors occurring in the future (Weick and Sutcliffe 2007).

1.8.3 Problems with service user involvement in forensic mental health services

Service user involvement in health care has become a feature of the modernisation agenda of the NHS, or at least of its rhetoric, with working in partnership with service users and carers becoming one of the gold standards for quality assurance (Tait and Lester 2005; DH 2004). National initiatives have also encouraged service users and the public to become involved with the commissioning health services (DH 2007b). Service user involvement within the provision of mental health care is widely viewed as a marker of quality and, as such has been adopted, as a policy statement throughout mental health services within the UK (Tait and Lester 2005). The vision for all mental health services in England and Wales is for care to be focussed on a combination of evidence based practice and service user defined notions of recovery (DH 2009). Mental health care is expected to be personalised and provided in collaboration with service users and carers (ibid). Service user involvement in the provision of forensic mental health services has been called for since 1992 and forms part of the best practice guidance for medium secure units (DH and Home Office 1992; DH 2007). However, the vision for service user involvement in forensic mental health care is a problematic one. Contradictions exist between rhetorics of service user involvement, evidence based practice, public protection and forensic mental health service user involvement. It is unclear whether an evidence base derived from empirical research or service user knowledge will drive service provision (Glasby and Beresford 2006). Furthermore the role of forensic mental health care of protecting the public as well as providing therapy for service users has meant that in comparison to generic mental

health services forensic mental health services have struggled to develop systems of working in partnership with users (Godin et al 2007).

Building on the Butler and Glancy reports (Home Office 1974; 1975), the Reed report provided guiding principles for the care of mentally disordered offenders (Department of Health and Home Office 1992). The report encouraged greater involvement of service users and carers in the planning and delivery of care, although it was acknowledged that, due to issues of security and safety, not all aspects of care could be guided by the service user. The majority of forensic services and health care professionals and researchers are interested in involving users in service development (Faulkner and Morris 2003). However, the involvement of users and carers in forensic mental health services has been slow to develop, possibly due to the difficulty of balancing service user involvement with the need for security (Department of Health and Home Office 1992; Faulkner and Morris 2003). The majority of service users cared for by forensic mental health services are detained under the Mental Health Act (2007). In consequence, open, free conversation and partnership working might be difficult to achieve as coercion is implicit in the legal status of the service user. Furthermore, as with generic mental health services problems exist with service user involvement due to imbalances in organisational power. For example, initiatives designed to enable the users to influence service delivery, such as the arranging of forums for discussion between service users with managers may in fact result in the reinforcement of existing institutional social structures and power relationships (Hodge 2005).

Service user involvement is expected to benefit both service users and forensic mental health services, through promoting social inclusion and the provision of effective, personalised care (Tait and Lester 2005; Godin et al 2007; DH 2007; DH 2009). However, the potential humanising effect of service user involvement would possibly move forensic mental health care towards communicative action and so presents a potential threat to the functioning of a system which purports to be based on technical approaches to assessing and managing risk (Godin et al 2007).

1.9 An international perspective

In the UK forensic mental health services provide care for mentally disordered offenders who have been diverted from various sections of the criminal justice system, such as the courts or prisons to mental health services. This system is unique to the UK mental health care, although other countries have drawn upon UK systems to develop their own forensic mental health service structure. Other countries provide mental health care for mentally disordered offenders, but they are often provided within prison services (e.g. in Australia, Canada and USA). In this context, forensic mental health care is delivered within correctional facilities, which in the UK would equate with prison health services rather than forensic mental health care. In some countries, such as South Africa, forensic mental health services operate solely to provide secure care to service users who have been found not guilty by reason of insanity and so do not take people transferred from prison.

1.10 Structure of the thesis

The thesis is outlined in the following chapters: literature review, and review of theory; methodology; results chapter one: service provider perspectives, results chapter two: service user perspectives; discussion; conclusions and recommendations for practice for future research.

Chapter 2

Literature review: Part one, a review of empirical research

2.1 Introduction

The aim of this chapter is to provide a critical overview of existing knowledge which is relevant to the present study of forensic mental health care. A vast literature exists regarding forensic mental health care. However, it can not all be included in this review. Therefore research literature, and theory that directly relates to the aims and the findings of the study, have been selected to be explored in this chapter. This review has been divided into two parts: part one, a review of existing empirical research; and part two, a review of theory.

As a grounded theory approach was taken it could not be known what literature would be relevant to the study before the data were collected and analysed. An initial review of the literature was undertaken to sensitise the researcher to the current issues within forensic mental health care. The areas of the balance of safety with autonomy, and risk assessment and management were evident within the existing literature, and so informed the aims of the study. However, these existing ideas within the literature could only be applied to the study if supported by evidence within the data (Dey 1999). Following the data collection and analysis, the issue of balancing safety with service users' autonomy remained pertinent to the study. However, risk emerged from the analysis of the data as a social status rather than in the context of the statistical measurement of risk, an area which dominates the literature. Trade-offs between safety and autonomy also emerged from the analysis of the data from the present study, but in terms of game playing and the management of risk status to achieve greater freedom for service users and for service users to achieve the mission of the forensic service and rehabilitate service users back into the community. Furthermore organisational elements such as multiple role expectations and role taking and were present in the data, and a core category of the regulation of communication identified. The search of the literature before and after the analysis of the data is described below.

2.2 A review of empirical research on forensic mental health care

This part of the chapter will situate the present study within the context of existing empirical studies which have a related focus on forensic mental health care such as those by Clarke (1996), Davies et al (2006) and Heyman et al (2004) which provide an insight into individuals' experiences of forensic mental health care. Research into the social and organisational aspects of forensic mental health care and the core category of communication and the management of risk status will be critically discussed in the context of the present study

In this section of the literature review the search was limited to empirical studies which were published in the English language. Because the operation of mental health services depends to strongly on national policy and organisational context, research directly related to forensic mental health care in the UK was primarily sought. However, as there is a paucity of literature relating directly to forensic mental health care and areas such as communication, and balancing safety with autonomy, the literature search was broadened out to include research regarding generic and prison based mental health and social care. Also due to the limited number of relevant UK based research publications, international literature from Anglophone countries (e.g.: Australia, Canada and USA) which have a similar forensic mental health system to the UK was included in the literature review.

In the initial literature search, which was undertaken prior to the commencement of data collection, the search terms were generated from the aims of the study. After the data had been analysed, the literature was searched again, using search terms developed from the themes that emerged from the study (particularly: MDT working, interpretations of risk, organisational censorship, and gossip. The terms were combined with the Boolean operators: and, or, not. The search terms used are listed below. The search term "science" was used to exclude the North American literature relating to forensic science which concerns the scientific investigation of crime.

Table 2. Terms used to search the literature

Primary search term	Boolean operator	Secondary search terms
Forensic	and/or	Mental health; psychiatry, service; nurs(\$)ing; security; therapy, risk, risk assessment; safety; care; participant observation.
Offender; prisoner; inmate	and	Mental health; mental illness; psychiatry
Homicide inquir(*)ies	and / or	Forensic
Organisation(*)al	and	Communication; silenc(*)e; gossip
Symbolic interactionism	and	Mental health; nursing; organisational communication; gossip; silence; participant observation.
Prison / corrections/ correctional facilities/ incarceration/	and	Mental health; psychiatry; risk assessment; participant observation; grounded theory; symbolic interactionism.

The health literature was searched using the following data bases: BMJ online collection, British Nursing Index, CINAHL, Embase Psychiatry, Medline, PsychINFO, Pub Med, . The social sciences literature was searched using: International Bibliography of Social Sciences (IBSS), and Social Care Online.

In addition to searching data bases, a broader, snowball sampling approach was also taken to the literature review. Reference lists of journals were searched, and journals that frequently appeared when searching electronic data bases were hand searched (e.g.: Health Risk and Society, the Journal of Forensic Psychiatry and Psychology). Similarly an author search was undertaken for authors whose work was frequently found whilst searching the literature electronically (e.g.: Mason).

The review demonstrates a gap in the existing knowledge of forensic mental health care regarding the understanding of risk within a social frame; a gap which the study seeks to address.

Research into forensic mental health care has traditionally been dominated by actuarial approaches to measuring and quantifying risk, or effectiveness of service delivery and treatment approaches, such as those for personality disorder or reducing recidivism. For example, studies have been undertaken regarding the accuracy of risk calculations using statistical risk assessment tools such as the HCR-20 and Static 99 (Langton et al 2009; Dolan and Doyle 2000; Doyle and Dolan 2006). Further studies have been undertaken regarding measures that can be taken to reduce inaccuracies due to differences between raters (Reynolds and Miles 2009; Martens and Kahn 2008). Many studies have also been undertaken regarding the efficacy of treatment approaches, in particular those for people with personality disorders who are cared for in forensic mental health services (Low et al 2001; Bateman and Fonagy 2000). These actuarial studies take a nomothetic approach which attempts to create laws that explain objectively measured phenomena. In actuarial approaches to assessing risk individuals are assigned to categories according to their attributes. Rules are then applied to those categories, for example that people who have offended in the past are more likely to offend in the future. This approach to risk assessment is not sensitive enough to provide in-depth understandings of single cases. Thus the application of the findings of studies that use an actuarial approach within a health system, which is striving to provide individualised care provision, is problematic (NHS 2007). Also factors may be identified that cannot be changed, for example a person's past history, and therefore may not provide opportunities for therapeutic work. In the past five years more research has been undertaken that uses an idiographic approach to provide more complete understandings of individual cases and to explore the social landscape of forensic mental health services. It is this social research that will be drawn upon to provide a back cloth for the findings of the present study.

Firstly the literature regarding service users' and providers' lived experiences of forensic mental health care will be reviewed. This will include the balance of safety with autonomy, the relationships between service providers, and the relationship between service providers and service users. Secondly, risk management will be considered within a social frame. Research that relates to risk as a social status, and differences in interpretations of risk will be considered. Finally the literature that relates to the

regulation of communication in an organisational context will be reviewed. Literature that concerns elements of the regulation of communication such as silencing, and gossip will be critically examined as well as research on the communication of risk within health care and the development of a safety culture.

2.2.1 Service provider and users' experiences of forensic mental health services

Studies of service users and providers experiences of forensic mental health services will be discussed below. Studies of UK forensic services will be reviewed. However as there are few UK studies of the social frame of forensic mental health care, international studies of forensic mental health care, and mental health services within the UK will also be critically examined.

The differences that exist between the structure and ethos of UK and international forensic mental health services must be taken into account when reviewing literature regarding forensic mental health services in other countries. For example, as outlined in chapter one, (section 1.9) forensic mental health services in countries such as South Africa and the USA operate under different legislative frameworks. Unlike the UK, users of forensic mental health services in these countries must have been found not guilty by reason of insanity; convicted prisoners with mental health problems are cared for in the prison setting rather than being diverted to forensic mental health care. However, despite the apparent differences between UK and international forensic mental health services, international studies provide an indication of the social context of secure mental health care services for individuals who have offended and potentially present a risk to the public and the difficulties encountered by service providers in maintaining safety security whilst also promoting service users' autonomy.

The small numbers of studies that have examined relationships between service users and providers of forensic mental health care in the UK have used qualitative approaches to explore the interactions between forensic mental health service users and service providers. The majority of these studies have generated data through interviews with service providers. Few studies have incorporated interviews with service users, and even fewer have used ethnographic methods such as participant

observation to provide a more detailed picture of the ecology of forensic services. Previous studies mostly foreground specific aspects of forensic services such as the balance between safety with autonomy and micro-social interactions between service providers (Clarke 1996; Peternelji Taylor 1999; Mason 2002). Therefore the complex organisational aspects of the construction and management of riskiness within forensic mental health services have been largely unexplored.

The present study used ethnographic methods of participant observation to map the social context of the research site. Ethnographic methods have rarely been used to research UK forensic mental health care. The only published study which was revealed by a search of the literature was that by Clarke (1996) which is discussed below. Informal as well as formal interviews with service user and provider participants were also used to examine the interactions between research participants during activities. Therefore, the current study is one of a small number of qualitative studies of forensic mental health care which are concerned with user and provider experiences. The present study provides a new perspective on forensic mental health care as unlike previous studies the core category which emerged from the data analysis was that of the regulation of communication. Communication was regulated by research participants in an attempt to manage their risk status. Service users and participants actively sought to manage others' perceptions of their riskiness and so protect themselves from perceived threats and facilitate the mission of forensic mental health services; to contain risk whilst also reintegrating service users into the community.

2.2.2 Service providers' experiences: the balance between safety and autonomy

The role tensions experienced by nurses delivering safety whilst also and promoting service users' autonomy in forensic mental health care settings were first highlighted by Burrows in 1991. Nursing and other health care staff often face ethical and professional dilemmas due to their dual roles of to providing security as well as care for users who are detained within forensic mental health services. The resolution of these dilemmas may mean a compromise is reached between promoting safety or service users' autonomy. Such compromises may then prove stressful for service providers as therapeutic or security roles may not have been fulfilled to their satisfaction (Mason 2002). Burrow's subsequent study of the treatment and security needs of patients in

special hospitals found that the balance between security and therapy differed between the special hospitals (Burrows 1993). In the study nurses working in three high secure hospitals in England: Rampton, Broadmoor and Moss Side (Ashworth) were asked to complete a survey regarding the security needs of the service users that they worked with. The respondents from Moss Side identified more security needs per service user compared to respondents from the other two hospitals. Differences also existed regarding the types of security risks that the respondents reported more frequently. Respondents from Rampton and Moss Side identified concerns regarding self-injurious behaviour significantly more often than respondents from Broadmoor. Furthermore across all three hospitals, the respondents did not identify security risks for 45% of the service users that they worked with. The differences in the responses of the nurses working in different hospitals were attributed to there being lower physical security at the Moss Side site, and to variations in staff training. Thus the calibration of security levels differed across forensic services due to differences in both institutional structure and culture. A search of the literature since Burrow's studies uncovered few empirical studies of the tensions experienced by service providers in balancing safety and autonomy. However, opinion pieces and theoretical papers were found (Peternelji-Taylor 1999; Mason 2002)

Difficulties experienced by service providers in balancing safety with autonomy were reported by Clarke (1996) and Cashin et al (2010). In the UK nurses provide security directly and so tensions may be internalised. In Clarke's study tensions were played out by staff through individual conflicts, which resulted in staff teams becoming polarised according to whether their focus was on security or therapy. Clarke (1996) used covert participant observation to investigate how safety and autonomy were balanced within a medium secure forensic service that claimed to operate as a therapeutic community. At the time of the study it was novel to use this approach within a secure forensic mental health setting (Clarke 1996). Since the study was published several medium secure units have used a therapeutic community approach to deliver forensic mental health care, particularly for service users with a diagnosis of personality disorder. In relation to the present study, the women's service (For a more detailed overview of the structure of the service studied see section 4.4) had in part modelled itself on a therapeutic community. A central tenet of the therapeutic community approach is partnership working between service users and providers, but this potentially poses a problem in forensic mental health services where providers also have responsibility for security and public protection. Despite being published 11 years

ago, Clarke's study remains relevant to present day medium secure mental health services, particularly as it provides an insight into how service providers manage the tensions of providing safety as well as promoting autonomy. Clarke (1996) undertook covert participant observation. He took on the role of a nursing auxiliary (health care assistant) and worked part time within the research site. Data were collected by the researcher through eavesdropping, observation and interview. Unfortunately little detail is provided by Clarke regarding the methods and methodology that he used. It would seem that the researcher was attempting to avoid the problem of the research participants reacting to the presence of the researcher and so capture a true picture of the interactions between service providers. However this approach raises ethical concerns, particularly regarding consent. In the present study the researcher attempted to reduce reactivity by spending long periods of time at the research site. Clarke's study differs epistemologically from the present study which uses symbolic interactionism to view interactions between individuals as joint actions, based upon intersubjective interpretations of social objects rather than seeking to map a fixed reality.

Clarke found that the nursing team was polarised in regards to therapy and security. He categorised nurses as carers or controllers according to whether they prioritised their security or therapy roles. This dichotomy was played out in the decision-making of the two groups regarding whether to give service users leave to the local community to test their trustworthiness and dangerousness. In the present study such decisions were taken by using apparently technical approaches to assess the level of risk posed by the individual. However, in practice service users needed to display compliance in order to be granted leave. Clarke (1996) also reported that nurses of all grades often failed to engage with service users, and avoided interaction by either undertaking paperwork in the office or reading newspapers in the communal ward areas.

In the Australian context of the study by Cashin et al (2010) nurses provide therapy alongside custodial officers who are responsible for security. Therefore, nurses must negotiate with custodial officers to fulfil their nursing roles. During observed interactions between service providers the power balance between therapeutic and security work was negotiated and declared. In the study, security had the most powerful position resulting in members of the nursing team becoming despondent as they felt unable to fulfil their therapeutic nursing role. Cashin et al (2010) undertook two discrete periods of observation together with formal interviews to explore the nursing culture in a

forensic prison hospital in Australia. Five themes were identified within the data. These were routine, therapy, physical care, interstaff (negotiating access with correctional staff), recording and observation. Nurses observed patients by camera and so undertook surveillance of service users rather than therapeutic engagement.

An associated theme that emerges from the literature is that of nursing staff disengaging from service users. This distancing could be associated with the tensions that staff experience in balancing security and therapy, difficulties in working with service users who have committed serious crimes, or who have challenging behaviours that may result in feelings of disgust or fear (Jacob et al 2009; Mason 2002). Working directly with personality disordered service users in forensic settings in in-patient settings has been found to be stressful for service providers, who report feeling drained and sometimes frightened (Fortune et al 2009). Dhondea (1995) considered disengagement with service users to result from burn out. She undertook an ethnographic study of nurses' activities in a forensic unit in Australia, using participant observation and semi-structured interviews with nursing staff. Four main themes emerged from the content analysis of field notes and interview transcripts. These were nurses' view of their professional identities, organisational practices, patterns of interaction and nurses concerns and dissatisfaction. The ward based nursing staff reported that they experienced the managers to be unsupportive and uncaring regarding their day to day problems such as violence perpetrated by service users. Also, it was reported that nurses distanced themselves from patients through retreating to the office or focussing on nursing tasks in order to avoid patient demands.

Mason (2002: 515) undertook a thematic analysis of the literature about forensic mental health nursing in the UK. He identified security versus therapy as the central dilemma for nurses working in secure settings in the UK, as within the UK nurses are responsible for ensuring public safety as well as promoting service users' autonomy. In addition nurses may find it problematic to engage a service user in therapy when they have committed a heinous crime. Related to the core theme of security versus therapy were themes of the management of violence, therapeutic efficacy and culture. Fear of violence and chronic stress within forensic nursing staff and erosion of belief in the efficacy of therapeutic work were linked to withdrawal from contact with service users, and to greater use of power and authority. Mason also found from the studies that he reviewed, that the local nursing culture was affected by the dominant nursing group.

Thus, if the majority of nurses favoured a custodial approach to care delivery, many other members of the nursing team would switch from promoting service user autonomy to being security centred. Mason developed a theory that described nursing practice in terms of binary domains. These domains included: control vs. lack of control, success vs. failure confidence vs. fear, and medical vs. lay knowledge. There are echoes of these binaries within the present study. However, service provider research participants expressed a lack of confidence to act decisively due to a fear of being disciplined for failure to control or contain risk. Notions of control also resonated with the concerns expressed by service provider research participants in the present study. Several service provider research participants expressed frustrations regarding the actions of service managers to protect the organisation in the face of external scrutiny and criticism which they felt had limited their freedom to make decisions regarding treatment. Consistent with Mason's work, medical and lay knowledge was drawn upon by research participants within the present study. Nurses did struggle to balance their lay knowledge and language with medical knowledge and language which affected the power balance between the nurses and other members of the multidisciplinary team (MDT), in particular the doctors.

Thus the experience of forensic mental health care reported in the studies above was one of divisions between service users and providers as well as between factions within the service provider group, which were enacted through different ways of balancing of safety with therapy and service users' autonomy. These findings resonate with the difficulties faced by users and providers of forensic mental health care that were described by research participants within the present study.

2.2.3 Relationships between service providers and multidisciplinary team working

The relationships between service providers in forensic mental health settings have largely been addressed in the literature through studies of multidisciplinary team (MDT) working. Forensic mental health care is provided through a complex network of teams within criminal justice, health, and social services as well as third sector organisations. Thus MDT working takes place both within and between organisational boundaries; the present study focuses on the former. Multidisciplinary teams working in different organisational frameworks may differ in the ways that the needs of forensic mental health service users and the mission of the forensic service is perceived. These

differences may then cause difficulties with multidisciplinary and interagency working (Davies et al 2006). Studies of MDT working are discussed below in the context of service providers' experiences of working together to provide forensic mental health. Models of MDT working are not reviewed. Only members of the multidisciplinary teams based within forensic mental health service were included in the present study. Thus the studies reviewed were also limited to members of MDTs within mental health services with the one exception of Whyte and Brooker's (2001) study which surveyed multidisciplinary teams working across a range of secure settings including prison, high secure and medium secure forensic services.

All of the studies reviewed identified tensions that exist for health and social care professionals working within a multidisciplinary forensic mental health team. These tensions mostly involved power imbalances and differences in professional values within the team (Shaw et al 2007; Whyte and Brooker 2001; Mason et al 2002). Often the least qualified members of the team, who spent the most amount of time with the service users, felt excluded from team support and the decision making processes (Whyte and Brooker 2001). However, tensions also occurred due to divided loyalties when service providers were members of more than one team. Also a perceived lack of managerial support resulted in team members experiencing greater role tensions (Whyte and Brooker 2001). There are echoes of these findings in the present study. Members of the MDT in the service studied often voiced frustration with the power of the consultant psychiatrist within the team, particularly when they believed unilateral decisions were made by psychiatrists which were counter to the values of their own profession. However, these frustrations were largely voiced outside of MDT meetings, and not in the presence of service users or external service providers. Similarly Dhondea (1995) observed nursing staff to act in a subordinate manner to doctors. Dhondea reported that during interactions with doctors, nurses were careful not to assert their opinions regarding patient care, so as not to undermine the position of the psychiatrist.

However, not all tensions arose from within the team itself. Mason (2002) found that as well as the tensions that existed between the service providers' professional framework and team working, that tensions associated with balancing security with therapy were experienced across the MDT. Mason et al (2002) undertook a study of multidisciplinary team working within one small (33 bedded) UK medium secure unit. Service providers

were surveyed regarding the strengths and weaknesses of the organisation in relation to quality management. The main tensions identified were: meeting responsibility to the team as well as to self when there were differences between the individual and group ideologies; reconciling differences between local and national policies particularly when there were concerns regarding peer review of professional practice and the balancing of security and therapy. Mason et al then explored how service providers managed these tensions. It was hypothesised that decision-making by service providers to resolve these tensions took place within a three level ethical code framework. These levels were: the ethical codes of reference from the individual's own ideological framework, Trust or unit codes, and professional codes of conduct. These areas may be mapped on to the category of the regulation of communication that emerged from the present study. It is hypothesised that the regulation of communication occurred in response to the need to meet role expectations within three main areas of self-forming groups, direct external influences such as Trust policies and wider areas such as professional codes. Mason et al (2002) noted that the different levels of ethical codes may result in conflict for the service providers, but did not explore this further. Thus, the literature indicates that service providers experience several tensions arising from expectations linked to the different and often conflicting roles that they perform in order to deliver forensic mental health care. The present study explores some of the conflicts that participants experienced in regulating their communication, and the salience of the different role expectations for participants (see results chapter 6).

2.2.4 Relationships between service users and providers

The balance between safety and autonomy is perhaps acted out in the relationships between service users and providers. The development of a therapeutic relationship is consistently valued by service providers in studies of forensic mental health nursing (Jenkins and Coffey 2002; Mason and Coyle 2008; Mason 2002). However, studies of the interactions between service users and service providers indicate that therapeutic relationships are complex and variable across different settings, users and providers. Furthermore relationships are problematic when service providers have several roles (Schafer and Peternelji-Taylor 2003). Empirical studies of the relationships between users and providers are reviewed below. Each study provides a different view of user-provider relationships, which illustrates the dynamic nature of relationships. However,

core themes of control, duration and perceived quality of the relationship emerge from the review.

Jenkins and Coffey (2002) undertook a study which revealed the complexity of forensic mental health service users' and forensic community mental health nurses' relationships. A questionnaire was sent to 122 forensic mental health nurses regarding compulsory community treatment and their therapeutic relationships with service users. The data showed that the respondents did not believe that the compulsory community treatment affected their relationships with service users, with the lack of choice for service users being seen as inevitable. The respondents felt that the duration and strength of the relationship was important. Contact was maintained with service users in order to undertake early interventions to prevent deterioration and thus promote the safety of others. Thus, rather than consider the difficulties in balancing safety with autonomy the nurses take it as given that they maintain control and service users have limited choices. However, they also value the quality and longevity of the relationship that they have with the service user. Thus the nurses' security role is accepted and not considered as conflicting with the relationship that they have with service users. This is a similar finding to that of the present study, where the dilemmas associated with promoting safety as well as autonomy providing security and therapy were not discussed by service users or providers and largely the provision of security by nursing staff was an accepted part of their role. However, several service user participants voiced that due to nurses undertaking security roles they had chosen not to build friendly relationships with members of the nursing team. Also both service users and providers discussed where the point at which security became overly custodial (see results chapters 6 and 7). Thus Jenkins and Coffey's study provides an insight into the complexities of using relationships to work therapeutically with service users who have offended and so are considered to present a risk to the general public.

Johansson et al (2006) found that the struggle for control was at the centre of problems between service users and providers. Johansson et al (2006) undertook an ethnographic study of a secure acute mental health ward in Sweden. Few service users who were resident at the time of the study were detained under the Forensic Mental Care Act. Data was collected by participant observation, informal interview and document analysis. It was observed that there was an open struggle for power between the staff and service user groups. Three themes emerged from the data analysis: to

have control and to lack control, which concerned the staff and to be controlled, which related to the service users. In the theme to have control, staff imposed routines, rules and coercion in an attempt to gain control of all service users. Patients were in a less powerful position, being dependent on the staff for even their most basic living requirements. However, service users also attempted to gain control. Service users monitored the staff practices and threatened to call the newspapers when they were dissatisfied with their treatment. Staff, when challenged by service users, stood together, and presented a powerful united front. Some patients tried to make themselves heard through silent protests and being passive, whilst others voiced their dissatisfaction. The study is limited as it focuses on micro-level interactions between two polarised groups which are not situated within a broader organisational context.

Schafer and Peternelji-Taylor (2003) explored relationships between forensic mental health service users and providers from a service user perspective. Twelve participants from an inpatient treatment programme for male violent offenders in a Canadian correctional facility were interviewed. Data were analysed using a constant comparative technique. Many themes emerged from the data regarding the development and type of relationships and the qualities of service providers. Trust, respect and integrity were valued by the participants. However, the participants were mindful of the potential for relationships to become coercive, subtly forcing the service user to conform to the rules of the facility rather than motivating the service user to change their behaviours and schemata. Service providers held the majority of the power in the relationship, and therefore there was potential for the relationship to become distorted. For the participants the power of the service provider caused them to comply with treatment regimes. As with the present study, the participants acted out displays of compliance with treatment regimes in order to avoid the perceived negative consequences of non-compliance. The regulation of communication also arose from the data analysis. The authors report that service users described having no voice in terms of a personal violation (p.616). To be heard by service providers was to be respected and treated as human. Incongruities and indirect communications by service providers to service users were described as problematic. The avoidance of direct communication with service users was understood by users to indicate that service providers' considered them to be difficult. Service providers were identified as fulfilling several roles: primary therapist, enforcer of rules, and a social role. Service user participants believed that spending social time with service providers was not worthwhile as they considered service providers' social roles to be inconsistent with

their security or therapist roles. Boundaries between service users and providers were also found by Schafer and Peternelji-Taylor to be problematic, particularly in relation to the service providers' gender. The participants reported that boundaries were not made explicit, and they often felt seduced by therapists to whom they were attracted. Such attractions were high risk as they often resulted in negative consequences for both the service user and therapist, such as a limitation of freedoms or being subject to disciplinary action. Boundaries within therapeutic relationships did not emerge from the analysis of the data from the present study. However, the setting of boundaries for the researcher presented difficulties, and will be discussed in chapter 4.

The power that forensic mental health nurses' hold and the impact on their relationships with service users was explored by Holmes (2005). Interviews were conducted with twenty-three nurses working in a correctional facility in Canada. Holmes drew upon Foucault's work and took a governmentality perspective to explore the themes of power within the data. The main theme that arose from the data was that of nurses as subjects of power, who linked the aims of the correctional services with the objects of power; the prisoners. Sub-themes of coercion, discipline and therapy were also identified. Holmes found that nurses worked as agents of the correctional services to provide control and discipline as well as mental health care. Service users were expected by nurses to conform to unit rules and engage with therapies. Disciplinary power was enacted through controlling users' activities and punished those who did not follow unit rules and routines, by calling for prison guards who would then undertake disciplinary measures such as restraining the individual. The therapeutic domain was one where the service user was expected to take responsibility for their own recovery and devote himself to treatment, which results in greater compliance by the service user (Holmes 2005:7). Data obtained in the present study, suggested that users' activities were controlled through the risk assessment process. To reduce their risk status service, users needed to attend and display willingness to engage in therapeutic activities. To gain the freedom to engage in activities of interest to them, such as football or shopping, and to try to speed their discharge, service users needed to achieve a low risk status. Thus following Holmes' study coercive and disciplinary power was legitimised through the risk assessment process.

2.3 Risk as a social status

As discussed above risk is a key theme within the existing literature regarding forensic mental health care. In the present study risk also emerged from the data analysis, in the context of game playing and social status. Literature relevant to risk as an ascribed social status rather than a scientifically measured entity is reviewed below. The literature is mainly drawn from studies of generic mental health services as there is a lack of empirical research within forensic mental health care regarding individual risk interpretation. Literature regarding service providers' interpretations of risk will be discussed, followed by material concerned with service user perspectives and involvement with risk assessment.

2.3.1 Interpretations of risk

This section will critically discuss studies of the interpretation of service users' riskiness by service providers. Many studies have been undertaken to explore service providers' assessments of risk. Studies have attempted to identify and explore the individual factors that influence health care professionals' judgements, with the aim of improving upon existing risk assessment in practice. The studies reviewed relate to generic mental health services. The authors consider service providers use of intuition to personalise the epidemiological factors listed in risk assessment tools to individual service users (Trenoweth 2003; Holdsworth and Dodgson 2003; Buckingham et al 2008). The literature indicates that risk regarding harm to others is largely considered by service providers to be associated with risk factors associated with individual service users rather than the social or environmental context (Buckingham et al 2008). Also service providers draw on their intuitions and personal knowledge drawn from therapeutic relationships with service users to make their assessments of risk (Trenoweth 2003; Buckingham et al 2008). This information, unique to individual service users, which is difficult to articulate and quantify has been found to be at the fore of everyday clinical decision-making, whilst research based evidence is backgrounded within the risk assessment and decision making process (Holdsworth and Dodgson 2003). Thus, risk is largely judged by service providers on the social and therapeutic interactions that they have with the individual. However, the use of

measures such as the gut instinct of the service provider may not be fully known to the service provider, nor articulated to the user (Langan and Lindow 2004; Stein 2002). Therefore risk is considered to be intrinsic to the service user, as judged by service providers who assign the service user with a risk label according to their personal knowledge and risk schema. As reflected in the findings of the present study, in order to reduce their risk status, and escape their assigned risk label, the service user must adapt their behaviour to meet not only the known demands of formal organisational risk assessment procedures, but also the tacit risk assessment frameworks of individual service providers. Service users are therefore required to infer these unspoken frameworks as best they can.

Trenoweth (2003) used a grounded theory approach to examine nurses' perceptions of the risk of imminent violence occurring on a secure mental health ward. As outlined above, Trenoweth found that the nurses who participated in his study relied on their personal understandings of service users which they developed through their therapeutic relationships with users. Trenoweth (2003) then explored the factors that the nurses used to form their personal understandings. The participants drew on their knowledge of the users' history of violent behaviour, back ground and beliefs and impact of mental health problem. These findings are echoed by Aflague and Ferszt's study of suicide assessment by psychiatric nurses (Aflague and Ferszt 2010). Aflague and Ferszt interviewed six psychiatric nurses in North America about how they assess service users' risk of suicide. The participants reported using intuition, past experience and other professionals' assessments rather than quantitative based measures to judge suicide risk. Furthermore Stein (2002) also found that mental health nurses in the UK relied on unsubstantiated gut instincts to make judgements about the risks that service users pose to others.

The idiosyncratic assessments of risk by service providers were studied in more depth by Buckingham et al (2008). They undertook an exploration of the non-epidemiologically based factors that influence health care professionals' assessments of risk in practice. Cues were identified that prompted risk assessment to be undertaken. Forty-six service providers from different professional back grounds were interviewed regarding risk assessment for specific threats such as self-neglect and suicide. A hierarchy of risks and risk factors were identified. Past history of risky behaviours such as engaging in violent acts was the risk component most cited by the

participants. Thus, the participants were utilising inductive reasoning regarding the probability of the risk behaviour recurring. Service user appearance during assessment, living skills, general behaviour, and insight into mental illness were also frequently cited. Participants also reported that they based their risk assessments on the effects that the user had on them during the assessment, in particular the feelings that they evoked, such as fear or anger. The risk of harm to others was given a greater priority than risks to the service user of self-harm and self-neglect. The focus on harm to others when assessing risk has been found to be more evident in secure forensic settings than in the generic mental health settings studied by Buckingham et al (2008) as well as Whitehead and Mason's comparative study of risk assessment in forensic and generic mental health care (Whitehead and Mason 2006). Self-harm and self-neglect may be considered to be long term, less urgent risks than the risk of violence to others. Furthermore, individuals who are judged to require secure settings are likely to have a known history of causing harm to others. The focus on the risk of harm to others is reinforced by the aims for medium secure services as stated by the department of health (DH 2007) which constructs forensic mental health service users in terms of a risk to others and rather than of people who might also be at risk themselves (Heyman et al 2010)

The findings of this study resonate with those of the present study. In the present study service users adapted their behaviour to the perceived risk assessment frameworks of individual providers with the aim of reducing their risk status. Thus, service user research participants tended to adapt their behaviours and appearance to counter negative emotional and cognitive reactions that they felt service providers had towards them (see results chapter 5). Furthermore, as clinicians rely on inductive probabilistic reasoning service users may reduce their risk status by not reporting incidents or problem feelings and symptoms to service providers. Again this was observed within the present study, and was the cause of concern for service providers who speculated on the reasons for the absence of reported symptoms by service users (see results chapter 5). Heyman et al (1998) relate the use of inductive probabilistic reasoning by clinicians and others to the assigning of a social stereotype. The authors argue that probabilistic thinking concerns expectations about the future rather than the establishment of a causal link. Social attitudes may be affected by the categories in which people are placed which may be entirely erroneous (see chapter 3). For example, on the basis of previous behaviour, service users may be labelled as being a high risk of violence by service providers. This is then likely to cause the service user to

be viewed differently by individuals who are aware of their risk label. This use of social categorising of service users according to their risk status may be considered in terms of service providers' disciplinary power (Holmes 2005). Service users activities are controlled through the use of risk labels, as they alter their behaviour to meet the requirements for reduced risk status.

Holdsworth and Dodgson (2003) used Bayesian reasoning to develop a model that would bring together the reasoning of practitioners with statistical models of risk, and so improve clinical judgement. The authors argue that statistical information regarding risk is of limited value to clinicians undertaking risk assessments as it does not take into account the idiosyncrasies of individual service users and their environment. As with Trenoweth (2003 and Buckingham et al (2008) it was found that clinical judgements were based on information specific to the individual service user rather than epidemiologically based risk factors. However, rather than debating the utility of clinical judgement versus actuarial predictions Holdsworth and Dodgson's study brought together clinical judgement and statistical models for risk assessment. The authors then proposed a model of clinical reasoning that is governed by factors that are internal and external to the clinician. Internal factors included experience and personality. External factors included the organisational climate and professional support. This is a very basic model of clinical reasoning. However, it brings together the individual clinician's personal frame of judgement with the organisational and wider political context of clinical practice. This link between reasoning, individual schemas of risk and the organisation is the essence of the core category of the present study; the regulation of communication.

2.3.2 Forensic mental health service user perspectives on risk assessment

A search of the literature indicates that little known about mental health service user perspectives about risk, and its assessment and management. Even less is known about forensic mental health service users' perspectives on risk. The majority of tools used for risk assessment within forensic services such as the HCR-20 and PCL-R (Hare psychopathy checklist) do not require service users to be involved in the process of risk assessment (Webster et al 1997; Hare 1991). Together with the findings of

research from generic mental health services, this might indicate that few service users are routinely involved in the risk assessment process (Langan 2008; Langan and Lindow 2004). The lack of communication by service providers regarding their assessments of service users was highlighted by Godin et al (2007) who called for a more participatory approach to both research and the provision care in forensic mental health services. In the current study, service users were the subjects of risk assessment undertaken by service providers. Thus many service user research participants described ways in which they negotiated their risk status with service providers such as through performing compliance to treatment regimes. The studies discussed below, explore risk assessment from a service user perspective.

Disparities between service provider and user views of risk were highlighted in a study by Ryan (2000). In this study a grounded theory approach was used to explore the experiences of mental health service users in regards risk management. Twenty-two interviews were undertaken with mental health service users. Service users identified everyday risks that they needed to manage on a day to day basis, such as those related to the stigma of having mental illness. Thus service users constructed risks very differently to service providers, who as discussed above, focussed on risks of violence and suicide. It was found that service users undertook one of three approaches to risk assessment: proactive, passive and no risk management. Proactive risk assessment included active measures to limit engaging in risky behaviour such as self-harming to relieve feelings of tension and urges to attempt suicide as well as planned actions such as summoning help from others.

Risk assessment and risk management activities that were undertaken by users of acute mental health services assessments were described by Quirke et al (2004). Quirke et al (2004) undertook an ethnographic study of life on an acute mental health ward. It was found that the acute ward was often quite volatile, with some service users feeling under threat of violence. Service user participants also reported that some service providers allowed users to antagonise other users. One of the themes that emerged from the study was that of service users' strategies for managing risk, that were undertaken independent of service providers' risk management interventions. In a similar manner to the participants in Langan's study which is discussed below, service users used active and passive means to manage risk. These included avoidance, warning others, and getting discharged or escaping. Thus, in order to manage

immediate risks associated with being an inpatient, service users engaged in activities that might be assessed by service providers as indicators of risk.

Langan (2008) explored the tensions around recent policy calls for service providers to promote service user involvement whilst also containing and controlling risks. Thirteen mental health service users who were considered by their clinical teams to pose a risk to other people were interviewed over a six month period. They were asked about their own risk status and whether health care professionals were undertaking risk assessments on them. Four themes arose from the data: that professionals were not discussing risk; the majority of service providers were not involving users in risk assessment; the majority of service users were not aware that they were being assessed for risk; there were differences in the views of service providers and users regarding the severity of risk. In the present study service users were told about the outcome of their risk assessment, and were aware that they were being assessed by the ward staff. However, they were not informed of the content of the assessment by service providers and were told the outcome of their risk assessment as a fait accompli. This lack of service user participation in the assessment process itself resonates with the findings of an earlier study by Langan and Lindow (2004) regarding service user involvement in risk assessment. Furthermore, the word risk was frequently used by service provider participants when asked to talk about their experiences of forensic mental health care, but not by service users. Risk assessment was not something that service users had control over, and was something undertaken in the background by service providers.

The studies discussed above have highlighted problematic areas in the assessment and management of risk in mental health care. These include: the use of clinical judgment versus actuarial methods of risk assessment; the use of service providers' personal frameworks to assess risk; disparities between service users and providers views of risk; and the limited involvement of service users in the assessment and management of risk. There is no universal construction of risk within mental health care, nor an agreed means to assess and contain it. Service users and providers must negotiate the different approaches to risk and attempt to manage their risk status within the social context constructed within forensic mental health services. The next section, will discuss the regulation of communication through gossip and silence, through which

in the present study, service user and providers participants tried to manage their risk status.

2.4 The regulation of communication within organisations

There is a vast literature on communication within organisations, which cannot all be reviewed here. This section will focus on the areas of communication which emerged from the data analysis. These are of silencing and non-reporting, gossip and regulation. An abundance of theoretical papers exist on the subject of gossip and communication within organisations. However, few empirical studies have been undertaken in the area of gossip and silence, and none within the area of forensic mental health care. Therefore a broad range of literature will be drawn upon from different fields of study to consider the regulation of communication within organisations. The contexts encompassed by the research include an ethnography of a Brazilian community (Sherriff 2000), public opinion research (Noelle-Neumann 1984), animal food manufacturers (Grosser, Lopez-Kidwell and Labianca 2010) and research using participants from several different organisations and industries (DeGouveia, Vuuren and Crafford 2005). The findings of these studies of non-health care organisations may be broadly applied to health care settings, such as that of the present study. However, it must be borne in mind that unlike many employees of commercial organisations, health care professionals are subject to professional guidelines and are accountable to their professional body and the public for their actions. The systems of monitoring accountability that health care professionals are subject to may impact on how they regulate their communication, a factor which will not have been captured by research that has been undertaken in non-health care settings. A limited number of theoretical papers have also been included where they support and add to the empirical research reviewed.

2.4.1 The regulation of communication

Communications within organisations are affected by internal politics, power imbalance, conflict and differences of opinion (Fineman, Gabriel and Sims 2010; Tourish and Robson 2006). In response to perceived social, organisational or cultural pressures individuals may choose to withhold or alter information, re-direct or alter the

manner of communication (Sheriff 2000; Noelle-Neumann 1984; Hart and Hazelgrove 2001; Henriksen and Dayton 2006; Bowen and Blackmon 2003). The reporting of dissent, failure and communications that are critical of organisational processes or managerial decision making may become demonised in organisations in crisis. The result of negative responses to critical communications may be the stifling of upward critical communication between shop floor workers and high ranking managers (Tourish and Robson 2006; Vakola and Bourdas 2005). Distortions of communication, particularly non-communication of failure have been found to cause problems for organisations, as warning signs of problems are ignored or suppressed, precluding proactive risk management (Hart and Hazelgrove 2001; Henriksen and Dayton 2006; Tourish and Robson 2006). Furthermore, the non-reporting of near misses prevents organisational learning (Hart and Hazelgrove 2001). However, the communication of sensitive information may be displaced into informal communication networks (Sherriff 2000). Thus, the communication of problems within organisations although officially suppressed may still occur through informal systems such as gossip (Itersen and Clegg 2008). Thus a complex system of informal communication regulation takes place within organisations, which is affected by employees' perceptions of managerial actions, and social pressures. These areas of self-silencing, suppression of communication and gossip were evident in the data, and formed the core category of the regulation of communication. Unfortunately little is known about silencing and gossip within organisations (Itersen and Clegg 2008; Blackman and Sadler-Smith 2009). The available literature relating to the core areas of silencing and organisational gossip are reviewed below.

2.4.2 Silencing

Silencing may occur within organisations as a result of different forms of censorship such as self or cultural censorship as well as direct managerial censorship, and reflects power distribution and political interests (Hart and Hazelgrove 2001; Sherriff 2000). Henriksen and Dayton (2006:1539) provide a helpful definition of organisational silencing: collective level phenomenon of saying or doing very little in response to significant problems that face an organisation. An example of this within the present study is the silencing of failure by ward staff due to their perception that they were in a relatively powerless position compared to senior managers within the organisation and so were likely to be punished for reporting failure. Sherriff (2000) explored the

phenomenon of the cultural silencing of racism within a Brazilian community. Sherriff (2000) refers to cultural silencing as a group process in which the motivations for silence were shared and rules for maintaining silence were socially and culturally codified. Racism although not spoken of was evident within Brazil. Sherriff used an ethnographic approach to explore concealment of racism within a Brazilian community. He found that the systems for maintaining silence regarding racism were deeply embedded within the culture and were self-perpetuating. Different groups within the community had different motivations to engage with cultural censorship. However, these motivations were largely associated with political oppression and hegemony. There are some parallels between the hegemony and silencing described by Sherriff in the Brazilian community with the dominant ethos of forensic mental health care services, and the differing views of service users and front line staff. An example from the present study would be the regulation of communication by research participants in an attempt to manage their risk status within the dominant ethos and regime of the forensic mental health service. The findings of the study provide some insight into how practices of non-reporting of problems as observed in the present study may become ingrained within health care organisations. Hart and Hazelgrove (2001) drew upon Sherriff's work to explore cultural silencing in the context of organisational learning within UK health care services. The authors applied the concept of cultural silencing to the findings of inquiries into adverse events within the NHS. The authors found evidence in the inquiry reports that junior doctors and nurses developed links of transgression in which they bonded together in the process of concealing and compensating for poor practice. Thus, health care professionals developed solidarity through breaching rules of good practice and covering for one another's failings. Bonds of transgression between ward staff were evident in the present study. Breaches of good practice regarding security were observed to be concealed by members of self-forming groups to protect one another from anticipated managerial censure.

Tourish and Robson's (2006) theoretical discussion of the distortion of upward communication in organisations identifies that differences between the views of high ranking and low ranking members of an organisation, together with a reluctance to hear bad news, can distort or silence the upward communication of failure and critical opinions. Thus, the organisational structure and culture are likely to have a great impact on how communication is regulated. Problems arise when information critical to the safe and effective functioning of the organisation is not communicated upwards. Therefore the organisation may not be able to effectively manage risks that have been

identified by lower ranking, front line staff. A study of silence within organisations was undertaken by Vakola and Bouradas (2005), the findings of which resonated with the work of Tourish and Robson (2006). The authors investigated climate silence within a software sales company. Three research scales which were developed and used in the study: top managers' attitudes to silence, supervisors' attitudes to silence and employees' behaviours to silence. Questionnaires were completed by groups of employees of the software company (677 employees). It was found that supervisors' attitudes to silence were the greatest predictor of employee's silence behaviour. This was followed by the attitudes of high ranking managers and then opportunities for communication. Thus supervisors who worked closely with employees affected the climate for communication more than high ranking managers who were more divorced from the workforce. Silence behaviour by employees was also correlated with low commitment to the organisation and poor job satisfaction. To address the problem of the upward communications in organisations, Weick and Sutcliffe (2007) advocate utilising systems from high reliability organisations such as those concerned with fire fighting. These include encouraging lower ranking individuals to ask questions and developing an organisational culture where individuals feel safe to report problems. Furthermore Weick and Sutcliffe (2007) encourage organisations to develop a workforce that is mindful and looks for failure. These values are reflected in the current NHS push to develop a patient safety culture where NHS employees feel able to say when they have done something wrong and learn from their errors (NHS 2008).

Noelle-Neumann (1993) developed the spiral of silence theory which explains the operation of self-reinforcing dynamics of which regulated communication within groups of people. The theory was developed in the area of rating public opinion, and emerged out of an investigation of the apparent disparities between exit polls and the votes that were actually made. Noelle-Neumann argues that individuals are more likely to express the opinion that they believe to be dominant within a particular context. Individuals are less likely to voice their opinions if they feel that they are in the minority, or that they will be socially isolated as a result. As individuals express the perceived dominant opinion the majority position is strengthened, and the minority position weakened. Therefore individuals are even less likely to express an opinion that is contrary to the perceived dominant view.

Noelle-Neumann (1993) explored this theory by undertaking several experiments where individuals were asked questions regarding their political views in different simulated climates of opinion. It was found that people are more likely to conform to the perceived dominant view. In addition fear of isolation was explored in simulated situations such as using scenarios of individuals smoking in the company of a group of non-smokers whilst on a train. In this experiment a sample of 2,000 people were divided into two groups; experimental and control groups. Each group contained smokers and non-smokers. They were then presented with sketches of people talking about smoking and asked to complete sentences in speech bubbles. The experimental group were given scenarios which included the threat of social isolation. It was found that smokers who were faced with social isolation from non-smokers, and others within their environment (passengers in the same carriage) were unlikely to engage in a conversation and defend their position as smokers.

The spiral of silence theory provides some insight into why individuals within an organisation may remain silent regarding organisational problems when they believe that they are in the minority, or that they will be socially isolated by their peers. In the present study some service provider participants described suppressing upward communication of failure in order to maintain their membership of a peer group. In a theoretical paper, Bowen and Blackmon (2003) applied the spiral of silence theory to an organisational context to explore how individuals chose between organisational silence and voice. They argued that people who are in an invisible minority, such as people who are gay, lesbian or bisexual will be more greatly affected by the climate of opinion, and the threat of isolation. The authors suggest that individuals should disclose their sexuality to their colleagues in order to promote trust within working relationships and to avoid distortions in organisational communication that are related to the management of identity.

Henriksen and Dayton (2006) offer a model of organisational silence which incorporates the individual, social and organisational factors identified within previous studies of organisational communication. This model provides a broad picture of the complexity of the motivations and processes of organisational silencing. Factors identified by the authors of need for conformity, diffusion of responsibility and the existence of microclimates of distrust echo the findings of the present study where distrust of senior managers by ward staff impacted upon the formation of social groups

which provided support and enabled responsibilities to be shared. However, in order to avoid censure, dissent together with information regarding failure and organisational risks were largely held within the groups and not communicated upwards within the organisational hierarchy. Thus risk management and learning could not take place on an organisational level. Henriksen and Dayton's model of organisational silence may be placed within a taxonomy of silence which has been developed by Blackman and Sadler-smith to differentiate between tacit organisational knowledge (the silent) and suppressed voice (the silenced) (2009). The present study is concerned with suppressed voice, both conscious and unconscious.

2.4.3 Gossip

Gossip may be defined as a device used to protect individual identities by denigrating those who are perceived to pose a threat (Paine 1967). Many texts focus on the negative impact of gossip on organisational functioning and advise how it might be stifled or prevented (Noon and Delbridge 1993; Michelsen and Mouly 2004). However, gossip may also have positive affects within an organisation, such as improving the flow of information, escapism, or the management of feelings of anxiety associated with job insecurity (Michelsen and Mouly 2004). Gluckman (1963) considered gossip as means to strengthen and perpetuate social groups as the values of the social group are articulated in the gossip. Thus organisational traditions and identity are maintained through gossip (Noon and Delbridge 1993). However, a study by De Gouveia, Vuuren and Crafford (2005) found that employees within an organisation viewed gossip in wholly negative terms. The authors interviewed twenty-five employees from several organisations and industries about their experiences of gossip. Case studies, rating scales and card sorting exercises were also used to elicit data. The participants consistently described gossip in negative terms. Gossip was associated with talking behind a person's back, disclosing sensitive information and destroying morale. The intention behind gossip was generally considered to be malicious, and the information conveyed unreliable or false. Thus the participants were largely unreflective about gossip. Gossip was considered by the participants to be something that other people did rather than something that most people engaged in. De Gouveia, Vuuren and Crafford (2005: 67) conclude by recommending that anti-gossiping policies campaigns and workshops should be introduced into organisations to educate employees on the possible serious consequences of gossip. The study was quite small scale and was not

conducted within a health care setting, and so may not be entirely relevant to the present study. However the view of gossip as a negative form of communication that needs to be eradicated greatly resonates with the view of high ranking managers within the present study who dismissed gossip as malicious and harmful.

In contrast a study of gossip within a health care context by Waddington (2005) discovered that people that gossiped derived benefits from gossiping even if as discussed above, gossip is largely disapproved of. Gossip was found to be feature of the emotional labour of nurses who used gossip as a means to express their true feelings about patients in a safe space, away from the formal organisational and professional arena. Waddington interviewed ten clinical nurse specialists about their experiences of gossip in the context of sense making and social group formation. The data analysis revealed the pervasive nature of gossip within the organisation studied and also that it was used for cathartic release of feelings associated with providing direct patient care. However, gossip was also described by participants to have a negative side, occasionally being used in a malicious manner, at the expense of others. In the present study, the use of gossip as a form of catharsis resonates with the participants' use of gossip to talk about their fears regarding threats to the organisation and their continued employment which could not be voiced within formal organisational meetings.

Through discussing problems within the organisation, gossip may be used to shape an individual's social role and identity. However, formal collaboration also forms individual roles, collective organisational identity and action (Hardy et al 2005). In the process of gossip collective identity is created through conversations, thus forming organisational identity as well as reflecting it.

Grosser, Lopez-Kidwell and Labianca (2010) used social network analysis to investigate the factors that influenced employees to engage in positive or negative gossip. Negative gossip was described as often blaming or criticising and had negative outcomes such as low morale within an organisation, upsetting individuals and undermining a person or organisation's reputation. Positive gossip was defined as supportive and praising. The research was undertaken in a company in the USA that

manufactured animal food. Psychometric and sociometric data was collected. The psychometric tests were used to assess the participants' opinions and perceptions. Sociometric tests were used to assess participants' friendships and work related ties with other people within the organisation. Surveys were then undertaken whereby participants were asked to name the work colleagues with whom they gossiped (gossip ties) and whether the gossip they shared was positive or negative. Furthermore rating scales were completed by research participants which asked them to rate level of informal influence that each person had within the organisation. Supervisors were also asked to rate the performance of employees. A correlation matrix was then developed. It was found that gossip only took place between people who had a friendship tie, rather than an instrumental work flow relationship. However, high levels of trust were required in a relationship in order for negative gossip to occur. Furthermore both positive and negative gossip was more likely to occur when an individual had multiple friendships and workflow ties. Gossip did not happen between people who were only acquaintances. Individuals used gossip to influence their peers and so gain some control over events that took place within their organisation. These findings are reflected in those of the present study, in which some research participants described how social groups influenced control over the behaviours of their members and others within their working environment (see results chapter 6).

2.4.4 Limitations of the studies reviewed

The studies of forensic mental, health care outlined above largely focus on nursing practice within forensic mental health services. Thus, the themes of hard work, and the balance of therapy and relationship building with security that are common to the studies might be indicative of the role of the forensic mental health nurse, rather than being major themes within forensic mental health services. In the UK and elsewhere, forensic mental health service providers need to be conscious of the need to maintain security. However, the task maintaining physical and procedural security falls largely to forensic mental health nurses. In non-UK contexts, forensic mental health nurses do not directly provide security, but must negotiate with security staff in order to fulfil day to day nursing tasks. The studies reviewed consistently found that mental health nurses working in secure settings experienced role tensions which arose from attempting to fulfil security and therapeutic roles. Also Clarke's observational study of UK forensic mental health care was undertaken fourteen years ago and forensic mental health services have changed considerably (Clarke 1996). However, the studies do provide an insight into the difficulties of providing care within a custodial setting, and

role tensions for nurses whose therapeutic nursing role is infringed by the need to provide security. There are resonances between Clarke's work and the current study, in regards to the interpretive frameworks of service providers regarding risk, therapy and control. Thus the findings of previous social research into forensic mental health care may be used to contextualise the findings of the present study.

There is limited empirical evidence available regarding gossip, silencing and the regulation of communication within organisations; even fewer within health care organisations, and none within a forensic mental health setting. The limited literature reviewed provides an indication of how the power and perceived threats within organisations affect how communication is regulated, and in particular dissent and reports of failure may be suppressed. These findings may be used to consider how in the present study, power within and between self-forming groups and externally imposed organisational structures affected the regulation of communication as research participants attempted to manage their risk status(see results chapters 5 and 6).

2.5 Summary and conclusions

This review has highlighted several main themes within the research literature:

1. Role conflicts are inherent to the provision of forensic mental health care. The central conflict between roles arises from providers being expected to ensure safety and security whilst also undertaking therapeutic work and promoting the autonomy of service users. It would seem that this conflict of safety versus autonomy pervades all aspects of forensic mental health service providers' work, and is particularly problematic for nursing staff in the UK as they are responsible for most security work.
2. Providers of forensic mental health services often fulfil multiple roles that constitute their paid positions of employment within forensic services. Nursing staff undertake dual roles of security manager and therapist.

3. Rather than being scientific, risk assessments often draw upon practitioners' personal frameworks which, it has been argued, is informed by and reinforces the social stereotyping of service users (Heyman et al 1998; Buckingham 2008).

4. Little is known about how service users in forensic mental health services engage in risk assessment and management processes, and their experiences of the tensions between working in partnership with service providers and the provision of security (Langan 2008).

5. With regard to organisational silence and communication, the literature reveals that negative organisation responses to critical upward communication of failure and identified risks may result in the suppression and displacement of sensitive communications.

6. Gossip often provides an outlet for tensions and aids communication within organisations. However, gossip can be detrimental to working relationships and is largely viewed negatively within the management literature (De Gouveia et al 2005).

The present study adds to the existing knowledge by providing an insight into both service users' and providers' experiences of a forensic mental health service. The study provides a greater understanding of how organisational, social and political pressures affect risk assessment and communication within a specific organisational context. Therefore the present study both builds upon the bodies of work reviewed and draws them together to provide a new perspective on forensic mental health care.

Chapter 3

Literature review: Part two, a review of theory

3.1 Introduction

This chapter is the second part of the literature review. The chapter builds upon the first part of the literature review by providing an overview and discussion of the theoretical foundations of the study.

The first section provides a discussion of symbolic interactionism in relation to the subject matter of this thesis: the regulation of communications as a way to try to manage risk status. In the second section theoretical approaches to risk are explored. Positivistic approaches to risk that underpin current risk assessment practices in mental health care are firstly discussed, followed by a review of risk theories that draw upon a symbolic interactionist frame. These approaches include cultural symbolic, governmentality and risk systems theory. Communication and the regulation of risk are discussed from the perspective of these theoretical positions. To illuminate the discussion and link theoretical short descriptions from the data are provided and links made to the research findings.

3.2 Symbolic interactionism

The aim of this section is to describe the theoretical foundations of the study, and so demonstrate the philosophical fit of the research design to the research question. Symbolic interactionism provided a framework for the development of methodology as well as a theoretical approach. In this chapter the theoretical position of symbolic interactionism will be discussed. The present section will also link symbolic interactionism with the analysis of the data and results that are discussed in chapters 5, 6 and 7.

3.2.1 An overview of symbolic interactionism

The foundations of symbolic interactionism lie in pragmatism and in particular the seminal works by Charles Horton Cooley [Human nature and Social Order (1902); Social Organisation (1909) and Social Process (1918)] and George Herbert Mead [The Mechanism of Social Consciousness (1912); The Genesis of the Self and Social Control (1925); Mind Self and Society (1934)]. In particular Blumer (1969) drew on the behaviourist approach of Mead, that society and self are founded on social interaction (Schubert 2006) to develop symbolic interactionism. Concepts developed by Mead such as intersubjectivity and the inter relatedness of mind, self and society were developed by Blumer into symbolic interactionism. In creating symbolic interactionism Blumer shaped Mead's philosophical approach into a theoretical and methodological approach which could be used to research human group life (Blumer 1969). Symbolic interactionism provides a theoretical basis for understanding how individuals make sense of their everyday life as part of a community in which they live, in the context of the present study the communities that existed within the inpatient units that formed the forensic mental health service. The symbolic interactionist approach focuses upon the interactions that take place between individuals within a group and their interpretations of social objects, rather than the psychology of the individual members of the community or the structure of society (Charon 1979). People are constructed as dynamic, interacting and changing according to their social context. (Charon 1979; Prus 1996). A dialectical relationship exists between the self and society, which is actively reinvented by each individual. In the context of the present study, service users and providers were engaged in joint actions in relation to the functions and social structures of the service, such as in the assessment and management of risk. The central principles of symbolic interactionism as defined by Blumer are outlined below. The construction of self and society within symbolic interactionist framework is then discussed in relation to the present study.

3.2.2 Central principles of symbolic interactionism

Blumer (1969) identified three tenets of symbolic interactionism which are outlined below. These tenets of symbolic interactionism were used to inform the analysis of the data, as discussed within the results chapters 5, 6 and 7. An example of this is how service provider research participants described examples of how they interpreted and

acted towards and risk objects (risk objects were often service users). The actions and interpretations of service provider participants then shaped the meanings that they had for that risk object.

1. Human beings act towards objects on the basis of the meanings that the objects have for them.

2. The meaning of things arises out of social interaction with other human beings. The meaning of the thing for a person grows out of the ways in which other persons act toward the person in regards to the thing.

3. Meanings are modified through an interpretive process by the individual interacting with the object.

Thus, meanings are social products created through the defining activities of people as they interact and reality is viewed as being socially constructed. Meanings are developed and drawn upon by the actor in the process of interpretation. The actor identifies the object that has meaning for him; he then actively interprets meanings through the processes of choosing, transforming or suspending meanings according to the situation that he is in. Thus, meanings arise from reflexive interpretations of social objects according to their context, which in turn shape the development of self. For example from the present study it was evident that service users managed their presentation of self relative to the situation that they were in through regulating their communication. Examples of this from the data include service users' descriptions of presenting differently when they were with service providers during working hours or alone with their peers during evenings and weekends. Therefore the perspective of the service users as social actors differed according to their interpretation of their social frame.

3.2.3 The self

Central to symbolic interactionism is the existence of the self which emerges from a dialectical relationship between the elements of 'I' and 'me'. The self develops through a reflexive process with the social environment. People are understood to develop a self which provides a guide for future interpretations. Thus the self cannot be understood separate from the social world. The self is not fixed but dynamic, being shaped by the social frame of the individual. Mead constructed the self as emerging from the relationship between a subjective 'I' which is natural and spontaneous and an objective 'me' which is the persons' interpretation of how they are seen by others. The 'I' and 'me' interact with one another, via an internal mental dialogue within a social context, and determine how the individual is to behave. Thus, social self is constructed through the inner conversation between 'I' and 'me'. Therefore the individual is an object to herself, reflecting upon her own actions, interpretations and meanings in order to plan and prepare for future action (Mead 1934). It is this reflexive, reasoning nature peculiar to humans that defines the self.

The self is variable and reflective, nuanced and shaded, and , as an object to itself and to others scintillates and reverberates in varying waves and beats and is forever responsive to the signifying stimulation of the environs - people and things, the things people say and the things that things say

(Perinbanayagam 1991:5)

However, reasoning is limited by the level of the development of the self, the "knowledgeability, boundaries and horizons of the mind" which contribute to the construction of reality (Perinbanayagam 1991). The development of service users' self as subordinate or subversive according to their interpretation of their social context was highlighted in the analysis of the data and will be discussed in the results chapters 5 and 6.

Goffman developed the concept of self in symbolic interactionism in his work the *Presentation of Self in Everyday Life* (1959). He explored the tension between I and me, the spontaneous and the socially constrained aspects of the self. Goffman took a

dramaturgical approach to sociological inquiry, with social life being seen as a series of public performances. The individual is an actor who may perform different roles according to their social frame: their audience and setting. For Goffman the self is the product of dramatic interaction between the audience and the actor (Ritzer and Goodman 2003). The actor seeks to be able present the self in such a way as to influence how the audience will respond to them. Furthermore, in order to manage problems that the audience might present, actors engage in impression management strategies. Problems might include unexpected reactions or intrusions. In relation to the present study, service users and providers were found to engage in activities to manage the impressions that others had of them, for example by service users game playing in an attempt to manage their risk status. Service providers' impression management may be considered in the context of professional role expectations.

However, actors sometimes do not fully take on roles that they are afforded (Goffman 1961). Actors may undertake activities designed to demonstrate distance from a particular role such as undertaking the role in an overtly careless way. Goffman termed this self-presentational strategy as role distancing. Service user research participants involved in the present study were found to engage in activities outside of the nine to five working hours when they were not under the watch of service providers that distanced them from their inpatient, service user roles.

3.2.4 Society

Blumer conceptualised society in terms of networks of joint actions and shared interpretations (Blumer 1969):

A society is seen as people meeting the varieties of situations that are thrust upon them by their conditions of life. These situations are met by working out joint actions in which participants have to align their acts to one another. Each participant does so by interpreting the acts of others and, in turn by making indications to others as to how they should act. (Blumer 1969:72)

Thus, it is understood that Individuals seek to articulate the self and to have some control over how they are understood by others. Individuals also act to understand the other in order that they will know how to act toward them. Thus society is the product of intersubjective group processes. Society is internalised within the individual as part of 'me'. This enables individuals to act in a manner that is expected by society, but always involves active, creative interpretation. In the present study service providers were considered to have internalised ways of being associated with their professional roles. However, in a symbolic interactionist frame individuals actively reinvent their culture, thereby contributing to societal change. Thus, professionals contribute to the development of their own profession through their own symbolic practices.

3.2.5 Symbols

Individuals' interpretations are influenced by perspectives that they gain from the roles that they perform within a group. Perspectives are then shared and learnt between people within the group using symbols of language and behaviours, such as facial expressions or waving as gestures of welcome or distress. Symbols within interaction are gestures that have shared meaning for the user and the recipient. Symbols may include language, acts and objects.

Symbolic interaction involves interpretation, or ascertaining the meaning of the actions or remarks of the other person, and definition, or conveying indications to another person as to how he is to act. Human association consists of a process of such interpretation and definition. Through this process the participants fit their own acts to the ongoing acts of one another and guide others in doing so. (Blumer 1966:537-538, in Prus 1996:71)

Thus, symbolic interactionism is based upon the notion that reality is socially constructed through human intersubjectivity. Meanings are shared and developed together with other members of the human group. Mead identified two forms of social interaction, which Blumer defined as symbolic and non-symbolic. Non-symbolic communication occurs when people respond directly to each others' gestures or actions. Symbolic interaction occurs when gestures are interpreted and responded to

according to the meaning of those gestures for the actor. Symbolic interaction requires definition and interpretation of conceptual objects as well as actions.

The use and meaning of symbols were the focus of participant observation and symbols associated with risk and security strongly emerged from the data. For example the allocation and use of keys was a potent symbol of power, and provided a clear dramaturgical distinction between service providers, service users and visitors.

3.2.6 Organisations

Symbolic interactionism has been criticised for ignoring macro level sociological structures and social systems (Meltzer, Petras and Reynolds 1975). However, within a symbolic interactionist frame, macro-level sociological phenomena such as large-scale social power, as well as mezzo level phenomena, such as the ethos of an organisation are understood in terms of micro-level sociological processes of interaction and interpretation. Thus, the properties of macro and mezzo-level social phenomena emerge from the dialectic between society and the self. However, examining micro social phenomena is often considered to be an unwieldy approach to exploring macrolevel social structure (Dennis and Martin 2005). Despite this view, a search of the literature reveals that there has been a recent resurgence in the use of symbolic interactionism to study organisations, and elucidate concepts such as power within them. Recently, symbolic interactionism has been drawn upon to explore individuals' experiences of residing or working within prisons, and secure mental health settings from the perspectives groups of actors (Walsh, 2009; Laithwaite and Gumley 2007; Muedeking 2009). Walsh (2009) undertook a study of the emotional labour of nurses working in prisons in England and Wales. Emotional labour was linked to four main relationships of the nurse with colleagues, the institution, the prisoner-patient and an internal intranurse relationship. The intranurse relationship represents an internal dialogue which occurs between the nurse's professional and emotion selves. Walsh concluded that to work effectively in prisons nurses need to develop their emotional intelligence in order to be able to manage the often contradictory discourses between their emotional and professional selves. Laithwaite and Gumley (2007) explored forensic mental health service users' experiences of recovery. They found that each participant had a personal story of recovery which often contrasted with that of other

service users. However, all of the participants identified relationships with family and members of staff as important to their journey of recovery, in particular how they redefined themselves. Muedeking (1992) observed interactions that took place within a prison visiting room in the USA. It was found that prisoners' identities were situational, with the presentation of self by prisoners within the visiting room viewed by the author as inauthentic to that of an incarcerated prisoner. In contrast to other theories symbolic interactionism does not assume fixed relationships between macro and micro structures and therefore enables research to be grounded in real situations, a strength which has been exploited for the present study as well as contemporary health care research (Dennis and Martin 2005).

Symbolic interactionism assumes that organisations are constructed of people engaged in interaction with one another in the performance of roles and the interpretation of their social contexts (Prus 1996). Organisational functioning is understood to occur through organised networks of human action. Thus the organisation is not an entity in itself but formed of complex human social processes. Mead defined institutions in terms of collective community responses to certain situations. The community responds in an identical way due to the development of the 'me'. The strength of using symbolic interactionism for institutional analysis is that it enables the researcher to consider how individuals interact with and interpret situations at their present points and how they interact with others rather than focussing on organisational policies or espoused ethos.

Large scale organisation has to be seen, studied and explained in terms of the process of interpretation engaged in by the acting participants as they handle the situations at their respective positions in the organisation (Blumer, 1969:58)

Thus, symbolic interactionism enables the researcher to gain an understanding of an organisation from the perspective of individuals and social groups that act within it. Within a hierarchical organisation such as the forensic service studied, the views and experiences of ward-based staff and service users may be captured and understood. Often, the staff that work at the lower levels of the organisation who are concerned with direct service delivery are possess most of the information required for the assessment

and management of risk, and yet often they are not involved in strategic level decision making processes. Indeed it has been recognised that, for organisations to function reliably, they need to have a mindful infrastructure that enables them to be sensitive to operations and track failures (Weick and Sutcliffe 2007:2) Symbolic interactionism enables processes such as risk management to be explored from the perspective of joint actions which occur at an operational level within the organisation. The symbolic interactionist approach enables the researcher to consider how individuals are linked, for example through lateral, or vertical social associations or through time. Therefore the ethos of different groups within which individuals act may be explored. The study revealed that individuals adapted their behaviours to the social group in which they were interacting.

Furthermore, by exploring the micro-sociology of organisations the focus is on the underdog, and their relationship with individuals in positions of power (Ritzer and Goodman 2003). Examples of studies of marginalised groups that have drawn upon the principles of symbolic interactionism through the use of a grounded theory approach include those of nurses working with forensic mental health service users, adolescents who are recent immigrants, and the construction of people with learning disabilities in the criminal justice system by professionals (Jacob, Gagnon and Holmes 2009; Garcia and Saewye 2007; Cant and Standen 2007). These studies indicate that symbolic interactionism may be utilised to explore concepts of power and power relations, in areas of marked power imbalance such as those of deviance and migration (Dennis and Martin 2005). However, as discussed in part one of the literature review, there are a paucity of studies that use symbolic interactionism to explore the lived experiences of forensic mental health service users in the UK.

3.3 Risk concepts and theories

This section will provide an overview and critique of current positivistic risk thinking in forensic mental health care. Theories that use an interpretive approach are then discussed and used to illuminate the theme within the present study of the management of risk status. The relationship between risk and forensic mental health care will firstly be examined, risk defined and risk theories discussed. An overview of technical approaches to risk will be provided within the context of forensic mental

health care. Social constructivist theories of risk that are consistent with a symbolic interactionist approach will then be used to explore risk from an interpretive perspective. Three major sociological theories that take an interpretive approach to risk will be discussed. These are the cultural and symbolic, governmentality and risk systems theories. The theoretical approaches will also be used to provide different perspectives on communication and risk regulation.

3.3.1 Risk in a forensic mental health care context

Forensic mental health care bridges health and criminal justice systems, providing a place for individuals who do not readily fit into either system. The characteristics of forensic mental health service users do not readily fit the specification of either system, and so the allocation of individuals to a health or criminal justice disposal is problematic (Prins 1999). Forensic mental health service users are detained in forensic mental health services to receive assessment and treatment for their mental health problems. However, due to the threat that users are believed to pose to the public care is mediated by risk and is focussed not only on health but also offending behaviours (Heyman et al 2004). Forensic mental health service users are subject to risk discourses related to both their health problems and offending behaviour. Indeed risk assessment and management are viewed as the corner stones of forensic mental health care (Mullen 2000). Risk emerged from the analysis of the data as an omnipresent social object within the field whose interpretation effected and affected joint action and the construction of the self within the organisation. Furthermore the dominance of risk in health discourse is evident even with a cursory search of health literature. Following a search of the literature Skolbekken found that the use of risk in medical journals had dramatically increased since 1967, leading him to assert that the term risk had reached epidemic proportions within the medical literature (Skolbekken 1995). Thus he viewed risk thinking as a harmful influence that had rapidly spread within the medical profession. Skolbekken hypothesized that the risk epidemic had arisen out of the reliance of the medical profession on technical approaches to risk measurement. The use of technical approaches has resulted in risk being viewed as under human control and lead to a preoccupation with risk avoidance. As a consequence risk thinking has directed attention away from iatrogenic risks particularly in medically dominated areas such as obstetrics. Furthermore Skolbekken (1995) highlights problematic areas for risk focussed health care of defensive practice,

misinterpretation and difficulties in setting levels for high risk groups. In the context of forensic mental health care the stakes are high, and errors in interpreting risks and setting levels of acceptable risk which are associated with serious incidents often result in severe criticism of practitioners and services (Warner 2006). Furthermore, although risk dominates service structure and delivery, the concept of risk in mental health is poorly defined with professional and academic literature, national policy and guidance seemingly using 'taken for granted' notions of risk (Skolbekken 1995:297). In the medical literature risk has been constructed as natural phenomena that may be measured by scientific tools and the interaction with society largely ignored.

3.3.2 Definitions of risk

Risk is an emergent concept which over time has changed both within lay and expert discourse. The origins of the term risk lie in maritime insurance in the middle ages. Risk relates to merchants daring to transport their goods by sea, with the expectation of making a substantial profit, but in the knowledge that their venture might be marred by events such as storms or piracy. Thus risk was used to refer to both potential natural disasters, such as flooding or plagues which were beyond an individual's control and the benefits to be gained from ventures. However, risk has since become largely dissociated from adventure (Heyman 2010). Following the Enlightenment, a scientific, probabilistic approach to risk was taken, and risk came to be concerned with human conduct and thus individual responsibility. In modernity risk was viewed as a neutral concept relating to an event happening, that could be viewed as both good and bad, rather than a danger that was to be avoided (Lupton 1999). Different theoretical perspectives of risk within contemporary society have been provided by Luhmann, Douglas and Foucault, which will be discussed later. Douglas argues that by the twentieth century, risk had lost its link with probabilistic thinking and become synonymous with danger (Douglas 1992). However Luhmann (1993) defined risk in terms of decision making with the existence of contingencies, and for Castel, (1991), drawing on a governmentality perspective risk relates to statistics derived from the study of populations. Thus different theoretical perspectives must be taken into account in the study of risk within a social science context.

Risk in contemporaneous mental health care systems has become associated with the prediction of an adverse event that must be averted or avoided and this with the notion of danger (DH 2007; Zinn 2008). Thus, health systems are biased towards safety, but in actuality this might not result in risks being reduced because regulatory activity may legitimate organisational activities without necessarily reducing harm. However, in the literature from the Department of Health the problems with a safety biased approach to health care have been recognised, and positive risk taking in mental health care promoted. Positive risk-taking entails risks being deliberately taken in carefully managed situations with the aim of enhancing people's lives, protecting their rights and promoting choice and autonomy in health and social care (DH 2007; Titterton 2005). Positive risk taking recognises the risks to the service user and the public and factors them into endeavours to balance of autonomy and safety. An example of risk taking would be to enable a forensic mental health service user to go into the community with an escort with the aim of encouraging social integration, whilst also limiting risks through continued supervision. Health care purports to take a scientific approach to risk, relying heavily on statistical and in particular probabilistic approaches to calculating risk (Berry, 2004). However, risk is a dynamic concept which is shaped not only by traditional statistical approaches but also by cultural views and theories such as economics, game theory and decision making (Peterson and Wilkinson 2008; Luhmann 2005). In relation to the present study, it was noted that during clinical discussions risk was often discussed in statistical terms. However, when decisions were made regarding the practicalities of managing risk, cultural rules of thumb were employed. Thus, although sometimes treated as a standalone entity that may be clearly defined through statistical measurement, risk is a contested concept with lay and professional discourses coexisting in everyday practice. The present study explored how the different conceptions of risk impacted upon the delivery of forensic mental health care.

3.3.3 Risk theories

Theoretical approaches to risk may be divided into those that take a positivist or naturalistic perspective and those that take an interpretive approach. Positivist approaches conceptualise risk as an entity which can be objectively measured. In contrast interpretive approaches view risk as socially constructed or socially mediated (Zinn 2008). The positivistic perspective emerged from a review of policy documents as the dominant theoretical framework, with national health care policy and practice

guidelines following technical and scientific approaches to risk. A critical overview the positivist perspective of risk is provided below in relation to technical and scientific, psychological and risk regulation in health care. An interpretive approach to understanding risk in forensic mental health care is then explored using cultural, governmentality and risk systems theories. These theories are used to provide the context for the analysis of the data from the present study, in particular the management of risk status through the regulation of communication.

3.3.4 Positivistic approaches to risk

Technical and scientific approaches to risk include those of psychology, statistics, epidemiology and economics. In these disciplines risk is viewed as a natural entity to be measured and controlled. Probabilistic approaches are brought together with hazards or danger to determine risk. (Lupton 1999). Actuarial, probabilistic frameworks presuppose that risks are pre-existing, and can be identified, located and calculated using scientific means (Lupton 1999). Furthermore actuarial methods of risk assessment are based upon statistical approaches and are primarily employed to evaluate factors in order to judge the likelihood of an identified risk occurring, within a given period of time (Denney 2005). The Royal Society defined risk in terms as:

the probability that a particular adverse event occurs during a stated period of time, or results from a particular challenge. (Royal Society 1983:22)

Thus, in this definition, risk is viewed as an entity which may be calculated using statistics. The Royal Society's definition divides risk assessment into risk estimation and risk evaluation. Risk estimation is the identification of outcomes, the estimation of the probability of outcomes occurring and an estimation of the magnitude of the outcomes. Risk evaluation is a cost benefit analysis, regarding the significance of the risk to those concerned. From the Royal Society's perspective, human interpretations should only be considered when evaluating risk. The severity and likelihood of risk must be measured scientifically. This approach is reflected in the Department of Health's definition of risk, in that it relates to a negative event, and can be dimensionalised according to its' severity and likelihood (DH 2007).

One major risk discourse in the context of forensic mental health care is one in which risks are viewed as an objective knowable phenomena if only the correct measures and tools can be designed (Kemshall 2008:31). There has been a drive to develop risk assessment tools that can reliably identify which individuals will reoffend and thus pose a risk to the public. Popular 'tools' such as the HCR20, Violence Risk Assessment Guide (VRAG) and the Behavioural Status Index that are used in forensic mental health care to predict future violent behaviour are based on a range of epidemiological risk factors (DH 2007; Webster et al 1997; Harris et al 1993). Historic risk factors the most predictive, but are fixed, and so reducing risk status depends on ratings of insight and social behaviour (DH2007) which may then link to risk status management manoeuvres. Thus the use of risk assessment tools link risk to acts of communication within forensic mental health care through constructing users' risk status according to their social interactions. Risk assessment tools including the risk assessment tool used at the site of the present study incorporate social behaviour and content of speech. For example the Behavioural Status Index (BSI) a risk assessment tool specifically developed for use within forensic mental health care has a communication and social skills subscale. This subscale has thirty items which include conversational interaction, potential conflict, self presentation and interpersonal skills (Woods, Reed and Collins 2003: 770). To reduce their risk status service users must therefore interpret how risk is constructed by these measures and behave in a manner which will lead to them being assessed as low risk.

Actuarial risk assessment tools enable psychiatrists and psychologists to predict violence at a level of accuracy better than chance alone, and so may be considered to be beneficial to clinical practice (Buchanan 2008). However, the translation of the results of actuarial risk assessment tools into clinical practice is problematic as clinical decisions such as whether to admit or discharge a service user are complex and dependent on many factors in addition to the assessed risk of an individual (ibid). Furthermore the application of aggregate inductively derived statistics to individual cases may be only weakly predictive. Also clinicians may not have the technical understanding to utilise actuarial approaches to risk assessment. The sensitivity and specificity of risk assessment tools and the limitations of their use may not be fully understood or considered by clinicians when assessing risk. Furthermore clinicians may not take into account the impact of the incorporation of subjective factors such as their own personal frameworks when utilising actuarial approaches to measure risk. Thus, clinicians using risk assessment tools may inadvertently presuppose a

“simplifying heuristic that statistics derived from aggregate groups can be validly attributed to individuals within them” (Heyman et al 1998). Therefore, probabilistic reasoning may be used by the medical profession to reduce and simplify a set of factors or elements with the aim of assigning individuals to risk categories so that risks may then be more readily controlled or contained. However, as mentioned above the main risk factors either cannot be modified or require qualitative judgements to be made by health care professionals, and are therefore subject to processes of symbolic negotiation. Associated with this approach to risk is the assertion of professional autonomy and status (Rose 2000). Thus professional groups who claim expertise in measuring risk are afforded greater power within the MDT to direct care delivery. In the current study consultant psychiatrists were observed to control risk assessment and decision making by the MDT. However, not all research participants agreed that psychiatrists had the expertise to effectively assess and contain risk. In the opinion of one service provider research participant psychiatrists falsely take on the mantle of the heroes of mental health care and pretend to be able to protect society from violent service users (see results chapter 6). Bauman argued that focussing on the calculation of risk is motivated by a hidden avoidance of greater worry concerning dangers that cannot be controlled, and so only an illusion of public safety is created (Bauman 2006). Not all risks may be attended to within a community, thus risks must be classified and a selection made as to which risks are to become part of the social consciousness and prioritised. Social groups may select risks according to perceptions of the common good and the response to risk might maintain social cohesiveness (Douglas 1992). Thus, although risks are considered to be natural phenomena, it may be argued that the interpretation, selection and politicisation of risks is cultural. Communication of risk may therefore be regulated in order to avoid insurmountable dangers being brought to the public consciousness. In mental health systems an organisational hegemony may operate, whereby the workforce is dominated by the hierarchy through conceptual practices policies and procedures (Lampe 2002: 131). Hegemony may be enabled and maintained by punitive approaches to dealing with problems, this is illustrated in the present study through service provider participants’ perceptions that failure to adhere to security policies result in disciplinary action being taken against them. Silence is encouraged as the cost of voicing concerns becomes greater than the benefit of the problem being solved (individual or reputational risk for the organisation) (Cox Edmonson and Munchus 2007). Thus systems of regulation may distort communications relating to health care risks as service providers seek to limit reputational risk for the organisation. Indeed risk assessment within mental health services has been described as a form of non-knowledge that emphasises negation

and avoidance that may serve to insulate existing norms of the dominant culture by encouraging a culture of fear and watchfulness (Crowe and Carlyle 2003: 25).

3.3.5 Psychological approaches to risk.

Psychological approaches to risk attempt to account for errors in individual risk judgements such as the misinterpretations of risk described above. It is alleged that lay people are unable to understand the science of probability, and are unaware of the limits of their knowledge. Therefore risks need to be selected, calculated and controlled by risk experts. Individuals may make different judgements if information is presented to them in different ways such as probabilities or frequencies, due to issues of numeracy and the employment of erroneous heuristic devices (Gigerenzer 2002). Thus individuals are subject to cognitive biases and emotional influences when evaluating information, and making judgements regarding risk (Berry 2004). Heuristic devices are “mechanisms utilised by individuals for the framing of information in relevant, accessible forms which make the world knowable and help interpret cues that we receive about the world” (Denney 2005:86). However, it may be that lay people whose application of probabilistic approaches to risk is flawed are in fact utilising a double heuristic. It has been argued that probabilistic reasoning itself requires the acceptance of simplifying rules of thumb. Therefore individuals who utilise heuristic devices such as the availability heuristic (discussed below) are in fact simplifying an existing simplification (Heyman 2010). In relation to the present thesis, as already argued, actuarial ‘tools’ generate predictions by applying aggregate, inductively derived statistics to individuals.

A rule of thumb is formed that enables order to be quickly created out of various risk discourses and events, and enables quick decision making, the benefits of which may outweigh errors in probabilistic thinking. In the context of forensic mental health care, it has been found that mental health nurses working in secure environments often draw upon their intuition to make on the spot assessments of risk within dangerous situations (Trenoweth 2003). However, heuristic devices used by individuals may have systematic errors or biases. Two devices that may be applied to managing risk following an inquiry are the availability and representativeness heuristics.

The availability heuristic relates to estimating how frequent events are on the basis of how readily examples can be retrieved from memory. The availability heuristic occurs when individuals have become aware of a particular danger. The danger then becomes available as a reference within the individual's consciousness, making them more likely to overestimate the recurrence of similar events or dangers. The availability heuristic was highlighted by a study which found that causes of death, that receive the most publicity are considered to be more likely than those that receive little media attention (Lichtenstein et al 1978). The hindsight bias is retrospective construction of an event given information that may only be known after the event. The hindsight bias is a perceptual shift that makes an event retrospectively seem inevitable and expected. Furthermore in estimating risks, outrage factors such as the dread factor may come into play, with risks that evoke fear or terror being judged greater than those that do not (Covello and Sandman 2001). An example of the employment of the availability heuristic is provided by the present study. During the study the forensic mental health service was criticised in a homicide inquiry report. The homicide and the publication of the report of the independent inquiry were widely covered by the media. Untoward incidents that had occurred at the hospital both before and subsequent to the publication of the homicide inquiry report were linked together by reporters. A case was then made that the forensic service was failing and that the users of the service presented a threat to the public. The repeated reports of the homicide by the media together kept the homicide in the public eye. Interview data from the present study indicated that the awareness of risk by service providers was heightened following the publication of the homicide inquiry report, particularly in relation to their own risk status (see results chapter 6). Thus, risk perceptions of service providers and possibly the public were affected by the homicide and inquiry report, with forensic mental health service users viewed as an ever present threat to the community, when in fact mental health service users are responsible for only a small proportion of the crimes committed every year (National Patient Safety Agency 2008).

The representativeness heuristic concerns how individuals judge the likelihood of an event according to a comparable known event and assume that the probabilities will be similar. Thus if several unconnected homicide inquiries are reported in the media the likelihood of another homicide occurring is likely to be overestimated, and the public's fear of forensic mental health service users heightened. Baumann (2006) provides a description of how the occurrence of serious untoward incidents may awaken hidden fears.

...dangers keep reminding us just how realistic they remain in spite of all the precautionary measures we have taken. On intermittent but quite regular occasions they are excavated from their shallow grave where they have been buried just a few inches below the surface of our awareness, and are brutally cast into the limelight of our attention; obligingly, successive catastrophes proffer such occasions – in profusion. (Baumann 2006:11)

Once dangers have surfaced into the consciousness of the public and health care professionals, the problem for organisations such as the NHS is how to allay public fears and using Baumann's metaphor, reinter risk. For the research site, additional security measures were put in place which did not relate to the circumstances of the homicide, such as reinforcing the unit doors.

Thus from a psychological perspective risk communication between experts and lay people is problematic. Judgements made by lay people are often flawed as they may be unable to think in a probabilistic way and so their responses to risk communications may be illogical. The challenge lies in enabling people to think rationally when estimating and managing risk. In practice the employment of technical and rational approaches to risk management in mental health care has been problematic as human factors affect interpretation. The lack of adherence to probabilistic approaches to risk measurement and management by mental health care professionals has often been highlighted in the findings of homicide inquiry reports (Warner 2006).

3.3.6 Technical and rational approaches to risk regulation in health care

This section will discuss second order risk regulation and its' affect on the core category of the regulation of communication to manage risk status. Second order risk regulation takes place through systems of monitoring which are used in an attempt to control how health care organisations manage risks.

The National Health Service and Department of Health issue professional regulatory and governance frameworks which determine the practice of health care providers.

Regulatory frameworks, such as that provided by the Essence of Care (DH 2006) are dominated by a discourse of risk assessment and the prevention of untoward events, through the use of a clear evidence base together with a system of monitoring and enforcement (Shaw 2010). Thus the Government's risk agenda uses a technical and rational approach to risk to interfere with market or social processes to control potential adverse consequences to health (Hood, Rothstein and Baldwin 2001: 9). In forensic health services risk regimes within complex institutional geography, and rules of practice, are employed in order to regulate risks posed to the public by service users. These include a graded system of security, to which service users are assigned according to levels of risk, assessed within a technical and rational framework. Alongside the imposition of governance frameworks, measures of compliance audit and inspection have been put in place within contemporary health care services. Power (2000) noted that since the 1980s there has been an audit explosion and the demand for accountability and transparency has increased together with the use of quality assurance methods for organisational control. However, seductive notions of rationality in the regulatory control of health risks are problematic (Shaw 2010: 179). For example the measurement of performance through the monitoring of clinical standards is problematic, which may be skewed by the need for services to reach targets or risk being penalised (ibid). Furthermore the existence of a rational system of risk regulation is challenged by varying degrees of risk tolerance within the health care service, with some risks being contained with intrusive measures whilst others are largely ignored.

3.3.7 Problems with probabilistic approaches to risk

As noted above, it would appear that the cultural and situational complexities of risk may be ignored by clinicians who misunderstand probabilistic approaches. For example individuals may erroneously believe that the characteristics of cases categorised together will be similar. The application of the actuarial approach to risk assessment may be objectifying, and devalue the complexities of the service user as a member of a social system (Lupton 1999). The construction of the service user as a risk object within forensic mental health services arose from the analysis of the data and is discussed in chapters five and six.

The use of probabilistic frameworks in risk discourse serves to remove a sense of uncertainty, and legitimate the heuristics of medical decision making through the aggregation of medical and risk knowledge (Douglas 1990). In so doing probabilistic epistemologies of risk locate the power to control the dangerous mentally disordered offender with specialised forensic mental health services. Furthermore belief in technical approaches to risk assessment may dissuade service providers from acknowledging their use of subjective risk factors, an area which the current study seeks to explore. Risk expertise provides the psychiatrist legitimate authority to ...assuage the anxieties of the public, and politicians about the dangerousness of individuals with mental illnesses (Mullen 2000: 307). The pressure felt by clinicians to espouse the ability of the medical profession to effectively assess risk in order to protect psychiatrists' mantle of risk expertise, is discussed in results chapter 6. Also the apparent complexities of quantitative risk assessment undermine the credibility of interpretive approaches to risk; setting up a requirement that forensic mental health care professionals who profess expertise in probabilistic techniques must therefore be trusted to calculate objective measures of risk (Lupton 1999). The present study found that the dominance of medical experts' probabilistic approaches to risk within multidisciplinary team meetings caused difficulties for other professionals who took a more interpretive approach to risk.

3.3.8 Interpretive approaches to risk

This section will contrast interpretive approaches to risk with the naturalistic approaches discussed above. A review of the literature reveals that few studies have utilised symbolic interactionist theory beyond the use of a grounded theory methodology to explore the concept of risk. The forensic mental health literature is dominated by the positivist approach. However, interpretive approaches, in which risk is understood in terms of a social object, co-constructed by actors within a specific context, have been taken by several major risk theories. Three major social science theories of risk are explored within the next section: cultural theory, governmentality and risk systems approaches. These three approaches have been chosen because of their relevance to the focus of the present thesis on the regulation of communication to manage risk status in the context of forensic mental health care.

3.3.9 Cultural theory

Douglas draws on the structural and functional approach of Durkheim to consider the purpose and importance of risk in the maintenance of social boundaries and rules that maintain the social structure (Lupton 1999). Douglas conceptualised risk as a way of the occident managing issues of danger through the differentiation and separation of self and 'other'. Thus although risk thinking is a feature of modern differentiated, science based societies, according to Douglas it should nevertheless be seen as a reframing of the concept of danger, which is found in all cultures. Douglas stressed the cultural relativity of risk, with socio-cultural structures providing unique frameworks to help people conceptualise risks, and therefore determine which risks are preventable, which are the most harmful and what should be their own role within the social group in managing those risks. Danger thinking is culturally universal but risk thinking is specific to science based societies. Risk within Douglas' cultural model is seen to be a politicised and moral concept which cannot be effectively assessed using a scientific approach which is based on presuppositions of neutrality. She argues that, therefore, the conceptualisation of risk in a scientific framework is intrinsically limited as it fails to consider the unique attributes and influences of the social systems to which it is applied, above all the cultural processes underlying the selection of certain risks and not others for organised concern. Douglas draws heavily on the work of Durkheim, and constructs risk as inherently political and tied to issues of accountability, responsibility and blame and indicative of the structural weaknesses of particular cultures (Douglas 1966; 1990).

She argues that the risks which receive the most attention are those that reinforce the moral principles of social groups (Douglas 1966). For example discussions of iatrogenic risks to the forensic mental health service user arising from their detention are largely absent from the literature. However, forensic mental health service users may be considered to be at risk from the risk management systems of forensic services which are "blind to the human consequences of regulatory practice" (Peterson and Wilkinson 2008:3). Forensic mental health service users are at risk from being unnecessarily detained within secure services due to the limitations of risk assessment and the use of a highly precautionary approach to public safety. However, individual or group vulnerability may be "adopted as part of a technical language that is designed to

specify problems for increased measures of expert intervention and technological control” Peterson and Wilkinson 2008:3).

In *Purity and Danger* (Douglas 1966) Douglas uses the body as a model for bounded social systems. The complex structure and function of the body is used as a source of symbols which may be applied to other organisations and social structures. For example, bodily control is seen to represent social control. Of particular interest to Douglas are classification systems of hygiene, purity and contamination, and related routines and rituals in the maintenance of social structure. She hypothesised that issues of hygiene, ritual and taboo have less force in the more robust, differentiated modern cultures compared to more cohesive ‘primitive culture’. Dirt is seen as matter out of place and represents the breaking down of boundaries and loss of separateness. Thus dirt may be conceptualised as being similar to danger and “risk may be understood as the cultural response to transgression: the outcome of breaking a taboo, crossing a boundary, committing a sin” (Lupton 1999: 45). The margins of society and the body are perceived to be dangerous as they are liminal, crossing and marking boundaries with the outside. Therefore, at the margins lies the threshold of society/the body, a potential weak point in the barriers to pollution and danger which requires greater monitoring than other parts of the system (Denney 2005). Rituals of purity are used to protect and maintain the social order, uphold the rules and to bind together the social/cultural group. In this process, ideas of pollution and purity may be used as a form of coercion to maintain the social order. Douglas specifies four types of danger that arise from social pollution: threats to the external boundaries of the system, transgression of the internal lines, threat at the margins, and internal contradictions within the community. Forensic mental health service users may be seen as polluting individuals as they have crossed social rules and so place others in danger due to their actions. Furthermore whilst resident within forensic mental health services, which arguably are placed outside of society, forensic mental health service users present a threat to the external boundaries of the system, by seeking to be discharged and return to society, or potentially escaping and illegitimately returning to the community. In primitive societies, taboo spontaneously declares the social consensus, and maintains categories and boundaries and so protects the social structure from behaviours that threaten to destabilise it. Primitive societies are those that are undifferentiated and in which belief systems are largely anthropocentric, for example the belief that man’s link with the cosmos makes things happen. A break from this happened with the first Copernican revolution when it was found that it was only the subjectivity of man that

made it appear that the sun revolved around the earth. This marks culture's move away from subjectivity (Douglas 1966). Risk may be considered to operate as a modern taboo that ensures an individual's conformity to the social norms and so strengthens the social order. Risk discourse has partly replaced sin in the modern secular society. Risk is therefore used as a means of social control. To return to society marginalised or excluded people must therefore demonstrate conformity to moral and social norms. However Douglas has argued that for those individuals whose behaviour crosses the internal lines, and subsequently enter the penal or mental health systems it may not be possible to reintegrate back into society.

A man who has spent any time 'inside' is put permanently 'outside' the ordinary social system, with no rite of aggregation which can definitely assign him to a new position he remains in the margins, with other people who are similarly credited with unreliability, unteachability and all the wrong social attitudes (Douglas 1966: 121)

Therefore, a very bleak picture is painted for forensic mental health service users who wish to reintegrate back into the community. Service users are maintained in the margins of society by the mechanisms of risk assessment and management; by the use of restriction orders, and monitoring by community mental health teams once discharged back into the community. The activities of individuals believed to pose a significant risk to the community are also monitored by Multi-agency Protection Panels (MAPPA) who provide another system of risk control through a convergence of criminal justice, social service, and health care systems of surveillance, and risk assessment and management approaches.

Using Douglas' work, forensic mental health care can be seen to serve a functional role in removing individuals whose aberrant behaviour crosses the internal lines of society. Certain transgressions, may be particularly threatening to the pervading culture whilst others may be less disturbing as they do not challenge prevailing views about human nature. For example robbery may be less disturbing as wanting money is seen as rational and fits with culturally accepted notions about human need. Anomalies within the social structure can be dealt with negatively, ignored and condemned, or

responded to positively through the creation of a new category within which the anomaly may be contained. Therefore, the development of forensic mental health care provides a resolution through the creation of 'a new pattern of reality' (Douglas 1966: 48) where individuals with mental health problems that present as an anomaly within health care and criminal justice systems can be placed. A taken-for-granted distinction is commonly drawn between 'rational' and 'irrational' crimes in relation to the prevailing cultural beliefs, with people who commit rational crimes such as theft being placed within the prison system, whereas those who commit seemingly irrational crimes such as in responses to hearing voices require both containment and therapy. Forensic mental health care operates on the fault lines of the mental health and criminal justice systems, absorbing and resolving anomaly created by the forensic mental health service user. Thus, danger is contained, and the structure of society apparently strengthened (Douglas 1966). The forensic institution therefore performs a kind of social magic in which offenders, often poor and from disadvantaged ethnic minorities, disappear into the multiple invisibilities of incarceration (Rhodes 2004:10). The forensic inpatient population has some contact with the community and vice versa. But, this contact is strictly controlled, even more so when incidents occur, as demonstrated in relation to the present study site, by the withdrawal of all service users' leave from the unit following the publication of a homicide inquiry report.

3.3.10 Governmentality

The governmentality risk perspective is based upon the work of Michel Foucault. Governmentality is an analytical approach to thinking about the transmission of organised societal power. It is concerned with the discourses in which problems are determined and subjects characterised (O'Malley 2004; O'Malley 2008). In his essay Governmentality Foucault outlined how government had moved away from a system of coercion and obedience to a governmental approach which sought to control individuals' self-governing capacities. The governmental approach pervasively governs the population through internalised governance. The prudent citizen shapes his conduct in relation to population risk factors selected and disseminated by the government.

Risk is a central technology of government, with risk strategies used to organise social and material worlds. Individuals act as good citizens, by managing or minimising risks. Individuals need to develop self knowledge and self control in order to respond adequately to warnings of risk. The management of risk by individuals is seen as a moral enterprise. Individuals are put under a moral obligation to manage themselves responsibly, guided by their knowledge of risk factors. Those who appear not to respond as expected may become stigmatised and the subject of moral judgement such as those that are stigmatised due to their obesity or who have contracted sexually transmitted diseases. Individuals must therefore internalise the principles of external governmental apparatus such as those based upon risk technologies to form a system of self-government (Lupton 2006). Research has provided insights into how service users self-govern and manage the risks arising from their own mental health problems, and also the risks that they are exposed to whilst resident within acute mental health care facilities (Ryan 2000; Quirk, Lelliott and Seale 2005). However, forensic mental health service users who attempt to manage their own risk status undermine the assumption of unreflectivity on the part of those who are assessed.

Castel (1991) applied the theoretical perspective of governmentality to risk and the field of psychiatry. He described how individuals can become thought of as a risk object, through being broken down into risk factors and reformed as a calculated risk. Risk factors become the focus of intervention rather than the individual. The use of statistical properties results in risk being regarded as real and objectively measurable. Castel (1991) identified a shift in psychiatry from the disciplinary technology of managing individuals' dangerousness to preventative measures that could be directed towards categories of individuals that possess specific statistical properties. The power of experts in psychiatry is eroded as subjective judgement is replaced by filling in actuarial scales of risk measurement. In the present study nursing staff were observed to complete actuarial risk tools, and categorise service users according to their assessed level of risk. In this process the forensic mental health service users were often constructed by service provider research participants as risk objects which were comprised of a set of risk factors to be identified and measured. However, Rose disagrees with Castel's view that statistical measures of risk dominate psychiatry. Rose claims that despite the adoption of actuarial measures of risk in mental health care, health care professionals continue to use their professional judgement to interpret risk calculations (Rose 1998). Rose's view is echoed by the data in the present study that strongly indicated that although risk assessment tools were used to measure risk,

clinicians used their professional judgement to interpret risk calculations (Rose 1998). Furthermore, clinicians were observed to react in different ways to the use of risk assessment tools, with psychiatrists resisting their use, but psychologists leading initiatives to train staff in the use of actuarial measures of risk. Thus the study validates both Rose's assertion that mental health professionals resist the use of numerical risk assessment tools, but also Castel's description that psychiatry had moved towards the use of actuarial measures of risk (Rose 1998). Therefore it is questionable how far psychiatry has gone in terms of using actuarial measures to determine how service users are to be treated.

In a governmentality framework, populations are viewed as the subject of surveillance and risk management policies. An example of this is the emergence of a new penology of crime prevention rather than the solving of crimes (Kemshall and Pritchard 1996). Thus there has been a shift from a justice to a predictive framework, which if taken to its logical conclusion would mean that forensic mental health service users who are assessed as presenting a high risk of future violent transgressions would be indefinitely detained in secure mental health service.

Furthermore technological systems of surveillance and apparatuses in society encourage people to engage in self-regulation (Denney 2005). Examples include the development of Multi Agency Public Protection Arrangements (MAPPA), which monitors service users within the community who are deemed less able than others to regulate themselves. Thus mental disorder and risk status leads to the suspension of neo-liberal Governmentality, and its replacement by a compensating coercive methodology. MAPPA requires health, social and criminal justice services to work together to monitor individuals such as repeat or violent offenders in the community who are considered to present a high risk to others. The technology of risk also defines new relationships and shapes social structures. For example MAPPA results in the creation of interagency partnerships that are based upon risk (Kemshall and Maguire 2001). Through systems such as MAPPA mental health care services have developed strong working links with the criminal justice system. Thus although mentally disordered offenders are diverted from criminal justice systems, within the new penology they remain under surveillance from criminal justice alongside the health and social care systems. The study revealed that the involvement of MAPPA and

surveillance systems was particularly evident for forensic mental health service users due to be discharged or living in the community.

3.3.11 Risk systems theory

Risk systems theory provides a different perspective for the analysis of organisations such as forensic mental health services that are concerned with risk regulation and constraints of functioning within society. Risk is understood as a modern phenomenon, associated with the consequences of functional differentiation, rather than as attributes of individuals such as forensic mental health service users. Society is viewed as fragmented, with subsystems creating risk objects (Japp and Kusche 2008) which results in a pervasive sense of insecurity. Societal members rely on specialist 'experts' but feel unable to trust them as co-ordination between subsystems is challenging. Thus, the theory places risk at the heart of modern society. Risk is a way of observing society, with events being observed according to the difference between the past and future, in the present of decision making. Time is considered in qualitative, non-linear terms. Society struggles to manage risk through various mechanisms such as by managing the environment.

In risk systems theory society is understood to be functionally differentiated; formed of observable subsystems with communication being the basic social operation. Thus society is constructed as a mass of communicative operations. Communications take distinct forms which associate them with a specific subset of society. Each societal subsystem performs a basic social function, and operates through communications that perform this function. Subsystems are self-referential with their communications referring to other communications within the system. Communication therefore relates to established orientations for correct operations, for example reinforcing what is established to be true or untrue. Thus subsystems reinforce their own logic. Events are understood in terms of subsystems for example, homicides committed by mentally ill persons being understood in health, social care or political terms. Conflicts may occur due to a lack of common ground between subsystems as each system functions according to own logic. No subsystem is considered to be more important than another as society requires all systems in order to function. In the absence of one accepted reality communication that is aimed at consensus is likely to fail. An example of communication difficulties is that of the communication of risk. Risk has been considered a conceptual pollutant, with groups holding their own concepts of risk, but

assuming that a common understanding exists (Dowie 1999). However, this is rarely discussed by clinicians, with the meaning of risk being largely taken for granted.

Systems of negotiation between subsystems are required for effective communication; differences between groups must be recognised and accepted without an assumption of what is real (Japp and Kusche 2008). An example of negotiated communication is that of multidisciplinary team working. Multidisciplinary team working is of particular importance in forensic mental health care as offenders' problems are often complex and require a coordinated response to enable them to progress through rehabilitation to discharge back to the community. However, clinicians may struggle to collaborate inter-professionally (Whyte and Brooker 2001). Shaw et al (2007) undertook a study of multidisciplinary team work in a regional secure forensic mental health unit. They found that there was a tension between members of the MDT associated with professional frameworks, and power. Similar to the findings of the study (see results chapter 6) tensions arose due to the dominance and power of the psychiatrist. Indeed Shaw et al found that "multi-disciplinary collaboration was a problematic and fragile process" (Shaw et al 2007: 363). Data from the present study are consistent with the work of Shaw et al (2007), with tensions arising between psychiatrists and other members of the MDT in relation to power, decision making and the construction of risk.

Systems theory makes distinctions between risk and safety, risk and danger, decision makers and other members of society. Risk and safety are both viewed as uncertain rather than absolute states. Danger comes from outside the system and so is unavoidable, whereas risk comes from within and so is viewed as preventable (Japp and Kusche 2008). Risk to the system is categorised according to whether the cause of harm is understood to have originated from within the system itself. Thus whether something is regarded as a risk is a matter of attribution.

Risk is inherent in decision-making concerns the future consequences of decisions. Decision-making involves selecting from a range of viable alternatives whose possible future outcomes are uncertain. Thus decision making is always contingent and risky, with risks that are taken by some people becoming further risks for others. Therefore, from a risk systems theory perspective entirely self-harm is not possible (Luhmann 2005). If something goes wrong as a consequence of a decision that has been made, decision makers are held responsible (Japp and Kusche 2008). An example from

forensic mental health care of taking risks for others is provided by the testing of service users' risk statuses. In an attempt to test the accuracy of their risk assessments and so gauge service users readiness to progress to discharge, multidisciplinary teams make decisions to allow forensic mental health service users venture into the local community unsupervised. Members of the public are not involved in or informed of the decision making process and so are not aware of the risks that are posed to themselves or family members. Therefore when something has gone wrong, for example, when a service user harms a member of the public there is likely to be a backlash from the media, public and politicians against the decision makers within forensic mental health services. Thus, a distinction is made between decision maker and the victim. The decision maker is held to blame, but it depends on judgement as to who within interacting systems is considered to be the decision maker and who the victim.

The existence of a resistance to probabilistic thinking may be attributed to individuals not wanting to be the victim of decision making (Japp and Kusche 2008). Calculations or arguments based on probabilistic thinking are rejected by people who are affected by decisions. Thus, although only ten percent of homicides are committed by mental health service users claims that mental health service users only pose a low risk to the public are likely to be rejected by victims (National Patient Safety Agency 2008). Furthermore as all subsystems are equal there is no external driving force to guide or limit decision making. Therefore, in the ongoing trend towards the flattening of central hierarchy in modern societies many possibilities for decision making exist. Subsystems are self-referential and so must create structures and experience in order to protect against open futures. Autopoiesis occurs with structure emerging from self-organised groups. However, these structures are contingent on decision making, and so allow ever new futures, which in turn require further decision making. The inquiry system communicates what was right and what was wrong about those decisions, and refines or reinforces decision making logic. New standards may be set for the organisation or individuals blamed and structures protected (Butler and Drakeford 2005). Furthermore the findings of the study revealed the existence of self-forming social groups, particularly at the lower levels of the professional hierarchy, between nursing staff. These groups developed their own structures to interpret and manage perceived risks to the group and its members, often those associated with organisational responses to the publication of the homicide report (see results chapter 7).

In risk systems context, risk cannot be eliminated. Safety is an uncertainty and so it is risky to act against and with social structures. Orientation of decisions to past selections is seemingly less risky. However, as organisations become more risk averse and less goal oriented in an attempt to deal with unknown future, more risks may be created. Opportunities may be lost and the organisation will stagnate. In the context of forensic mental health care, if services become risk averse service users are likely to suffer harms associated with prolonged detention and social exclusion. Furthermore, a central issue for risk systems theory is the fragmentation of specialist roles and the ensuing problem of coordination. In the case of the research site, co-ordination between fragmented clinical and managerial specialist roles had become even more fragmented through ethnic and linguistic divides.

In the context of risk systems theory, risk regulation, focuses on the ways in which subsystems deal with risks according to the communicative logic of the system. The analysis of the data revealed that the forensic mental health service studied overtly constructed risks in probabilistic terms which was then managed through balancing service user autonomy with calculated risk. However, within self-forming staff groups, risks were constructed in relation to threats to employment, and for service user groups in terms of threat to self identity or freedom. Subsystems also to seek eliminate risks to organisational survival by shifting them elsewhere, creating new risks for other organisations (Rothstein et al 2006). The complexity of the forensic service studied and the focus on risk resulted in risks regularly being negotiated and passed between organisations functioning within health, housing, criminal justice and social care systems, as well as the different professional groups that comprised the Multidisciplinary team. The negotiation of risk ownership was particularly evident during Care Programme Approach meetings in which plans to admit or discharge service users were discussed. Furthermore, risk communications which were constructed as a threat to the organisation might be silenced within one subsystem and transferred to another.

Self-censorship was described by service provider participants as being employed as a protective measure by staff who were fearful of the Trust response to failure in the context of a recent homicide inquiry. Censorship was often focussed around formal

reporting structures such as the complaints system, the disciplinary process and the process of investigation into serious untoward incidents. Thus censorship largely occurred in response to a perceived threat, of disciplinary action or other punishment for voicing dissent or an uncomfortable, unwanted truth.

In the present study service users and providers described remaining silent within regulated spaces within the organisation, but voiced concerns and communicated risk within self-forming groups. Senior members of the organisational hierarchy overtly discounted communication within self-forming groups as unfounded gossip. However, during the study managers were also observed to engage in illicit gossip with peers. Gossip within social subsystems was an important method of sharing information and conveying group membership. Furthermore gossip may also service as a mechanism for the cathartic expression of emotions (Waddington 2005). However, peer group pressure to self-censor was also reported by participants to occur within informal groups. Through limiting of the group's voice to insiders, the groups were able to influence their environment and become more powerful – through the development of social capital. Thus silencing through censorship was more complex than the oppression of the less powerful or marginalised groups within the organisation.

3.4 Summary and conclusions

This review of theory has demonstrated how a symbolic interactionist approach enables the experiences of hidden populations, such as forensic mental health service users, to be explored. A symbolic interactionist approach in constructing organisations as networks of human action brings the focus of the research onto microsocial interactions between actors in the field. Therefore a symbolic interactionist approach allowed the forensic mental health service in the present study to be explored from the perspective of service users and providers. The use of symbolic interactionism to aid the analysis of the data within the present study is discussed in the next chapter; chapter 4: methodology and methods.

The review also revealed that the naturalistic perspective on risk dominated the literature on forensic mental care. However, the use of technical and scientific

approaches to risk measurement has been found to be problematic. Interpretive approaches to risk provide alternative understandings of risk, as a cultural and politicised concept. In an interpretive frame the meanings that people have for risk shape and reinforce social structure. Thus risk is more than a stand alone object to be measured. An interpretive approach has been taken within the present study to explore how participants interpreted and responded risk as a social object; for example by attempting to manage their risk status through regulating their communication. The current study provides new insights into risk within forensic mental health care by bringing together notions of risk, regulation and communication within a symbolic interactionist frame. These areas will be explored in relation to the data within chapter 7: discussion.

Chapter 4

Methodology

4.1 Introduction

This chapter will outline the design of the present study together with the research process that unfolded as the study progressed. An overview of the research methodology and methods that were employed to achieve the aims of the study are provided. The grounded theory methodology used is presented and ethnographic methods of participant observation and interview explored in the context of the present study. The research site is described and the positioning of the researcher within the field is discussed. The quality of the data and the ethical issues encountered are then considered. The process of data analysis is presented within a grounded theory framework. Open, axial and selective coding are discussed in relation to the present study.

4.2 Aims of the study

The study had three main aims. The first aim was to develop a greater understanding of the complex formal and informal risk assessment and management processes found within a secure forensic mental health service. The second aim of the study was to investigate the processes through which providers and users of medium secure forensic mental health services balanced safety with promoting service users' autonomy in the process of rehabilitation. To achieve an in depth understanding of risk management in the context of forensic mental health care the study sought to explore organisational culture and structures, multi-professional relationships and communication strategies adopted by service users. The third aim of the study was to generate recommendations for the development of forensic mental health services.

The aims of the study were derived from the review of the literature. Furthermore, due to the clinical back ground of the researcher (see reflective statement) the aims of the study were deliberately embedded in developing knowledge of forensic mental health

practice and contributing to the improvement of forensic mental health service provision. However, although the development of the research protocol was informed by the researcher's experiences of working in forensic mental health care and the review of the literature, the study was firmly grounded in the experiences of research participants and so was shaped by the processes of data analysis and changes to conditions in the field. As the study progressed, predominantly organisational rather than clinical perspectives on risk emerged from the data. Thus risk status was constructed by research participants' perceptions of organisational as well as clinical and statistical risk factors. Emergent themes were linked by concepts of risk. The core category that emerged from the analysis was that of the regulation of communication, a process through which research participants attempted to manage their risk status.

4.3 Research methodology

The primary focus of the present study was to explore processes of risk assessment and management in one secure forensic mental health service. The study sought to tap into the personal social worlds of service users and providers as well as the official and public, systems world of the organisation.

A grounded theory methodology was used for the study as it provided the systematic and inductive approach that was needed to enable service users and providers experiences of forensic mental health care to be explored. Furthermore grounded theory procedures provided the researcher with the flexibility to adapt to a novel and unpredictable field of research, and yet remain grounded in the data and so the voice of the research participants.

This choice of methodology proved robust when, early in the data collection period the social climate in the research setting changed dramatically. The conditions within the research site changed substantially following the publication of a critical homicide inquiry report and a subsequent national media furore. These discussed in detail in section 4.4.

4.3.1 The epistemology of grounded theory

This section will explore the grounded theory methodology according to its epistemological frame. Glaser and Strauss' grounded theory has its roots in the combination of two distinct frameworks from empiricist and sociological traditions. Glaser brought quantitative survey methods from the University of Colombia; Strauss, symbolic interactionism from the University of Chicago (Dey 1999). Strauss was influenced by symbolic interactionism, pragmatist philosophy and the work of theorists such as George Herbert Mead. In partnership with Glaser, Strauss drew upon these influences to develop grounded theory. In particular Strauss assimilated the assumptions of Mead that action, process and self-agency are most important to human existence and that structure is created through social action (Charmaz 2006).

Thus grounded theory benefits from the structure and rigour of Glaser's quantitative method as well as Strauss' interpretive approach. Grounded theory draws upon symbolic interactionism to explore human lived experienced through the study of the meanings that emerge for individuals through their interactions (see section 3.2). As individuals are viewed as dynamic it is assumed that the meanings they develop are dynamic, not absolute and will vary both between individuals and over time (Dey1995). Thus the researcher uses grounded theory to develop an explanation regarding individuals' interpretations of their interactions, and the meanings that they have for things in a particular social frame (Yun-Hee 2004). The exploration of the experiences of actors using a symbolic interactionist frame is described by Blumer.

Action is forged by the actor out of what he perceives, interprets and judges, one would have to see the operating situation as the actor sees it, perceive objects as the actor perceives them, ascertain their meaning in terms of the meaning that they have for the actor, and follow the actor's line of conduct as the actor organises it – in short, one would have to take the role of the actor and see his world from his stand point. (Blumer 1969: 73).

Therefore the researcher must immerse himself within his field of research to gain an understanding of the meanings that people have for social objects as well as observing individual and group action.

Grounded theory emerged from the work of Glaser and Strauss who developed of a systematic set of strategies for analysing qualitative data and inductively developing theory grounded in the data. However the work of Glaser and Strauss later diverged. Glaser remained relatively true to the comparative approach of grounded theory whereas Strauss developed a more interpretive approach (Charmaz 2006). The study follows a modified grounded theory methodology which stresses principles rather than techniques, particularly principles of theoretical sampling, constant comparison and overlapping stages of open, axial and selective coding, which will be discussed below (Strauss and Corbin 1998; Corbin and Strauss 2008). An interpretive approach has been used in the study. Interpretive social research assumes that there are many different realities, and views the truth as being provisional. Therefore the researcher seeks to interpret, understand and conceptualise the studied phenomenon in abstract terms so that meanings and interpretations of reality are uncovered.

The theory of symbolic interactionism emerges largely from the work of George Herbert Mead at the Chicago school of sociology and is based on the philosophy of pragmatism. See chapter 3 for a discussion of symbolic interactionism in the context of the present study.

4.3.2 Grounded theory

Grounded theory provides a non-prescriptive tool kit of procedures and guidelines for qualitative analysis which is underpinned by a methodology, and agreed assumptions of how social reality may be studied (Charmaz 2006, Strauss and Corbin 1998). Indeed Strauss and Corbin encourage researchers to deviate from the procedures and techniques that they present in order for grounded theory methods to evolve. However they remind the researcher of the importance of following the underlying grounded theory methodology and employing constant comparative techniques to guide the direction of the research design, data collection and analysis (ibid). The methods,

techniques and procedures provided are simply viewed as the means to reach the vision provided by the methodology. Grounded theory was chosen as it would enable theory to be discovered that was grounded in participant concern. Also grounded theory provided the flexibility needed for the study to be viable within a closed and secure setting, in which the researcher's activities were restricted. Through the flexibility that the grounded theory approach affords to data collection, access to the research site was maintained despite difficult periods for the service following the publication of a homicide inquiry and subsequent media attention (see section 4.6). For example the study was adapted to work with the restrictions placed on access to management meetings, the closure of part of the research site (the intensive care ward) and rapid changes in the membership of the management and clinical teams. Formal interviews were undertaken when observational data could not be collected.

However despite the flexibility that grounded theory allows the core components of the approach were maintained and protected as the study progressed. Charmaz (2006: 5) defined the main components of grounded theory, which must be maintained to retain the essence of grounded theory.

- Simultaneous involvement in data collection and analysis
- Constructing analytic codes and categories inductively from the data
- Using the constant comparison method in all stages of the analysis
- Developing theory at each stage of the data collection and analysis
- Memo writing, to aid analysis
- Theoretical or purposive sampling, aimed at developing theory from themes that emerge from the data
- Reviewing the literature after analysing the data independently

The study followed a grounded theory approach for design, data collection and analysis as listed above, with the constant comparative method being employed and analysis occurring simultaneously to data collection. Analysis of the data was then used to

inform theoretical sampling. Memo writing during analysis and field work was also employed. Ethnographic methods of participant observation and informal questioning have also been employed for data collection.

4.4 Research design

The study was designed to include three stages;

1. Mapping the organisational context, through formal interviews with service providers and a review of local policy.
2. Exploring risk assessment and management processes through informal interviews with service providers and users and observation of the activities taking place in the secure wards (women's ward, intensive care ward, acute admissions, rehabilitation and low secure wards).
3. Dissemination of findings, obtaining feedback about preliminary research findings and development of proposals for future practice and policy, through focus group discussion with service user and provider research participants.

Stages one and two of the study were merged due to practical issues of navigating security processes and obtaining access to research participants, particularly following the publication of a homicide inquiry. Also, following a serious untoward incident, which became a national news story, the service was re-structured. The restructuring of the service impacted upon risk management practices and the physical location of research participants. The intensive care ward was closed and some service user research participants were moved to other services elsewhere in England. These changes to the service resulted in access to research participants becoming more problematic, and the concerns of service provider participants shifting to focus on risks to the organisation and their continued employment. Service providers who worked in the intensive care ward were formally interviewed before they were re-deployed.

Informal interviews were undertaken with high profile service users before they were relocated to other secure units.

4.4.1 Advisory group

An advisory group was established which contributed to the research design, and the analysis of the data. The advisory group comprised clinicians, researchers and forensic service users. Advice was provided by the group regarding the practicalities of gaining access to parts of the research site, and in working sensitively with service users and providers. Feedback from the advisory group was incorporated into the research protocol.

4.4.2 Access to the research site

Prior to the commencement of the study written agreement for access to the research site was given by the clinical service manager of the forensic mental health services. To gain the approval of the clinical service manager, the study was also discussed with the clinical director, research and development lead, consultant psychiatrist team and the forensic general manager all of whom gave their verbal permission for the study to take place. Managerial approval was subject to ethical approval. Ethical approval was subsequently obtained from the relevant Local Research Ethics Committee (LREC), and an honorary contract with the NHS Trust obtained. Initially, access to clinical areas was unproblematic. The method of data collection and access to ward areas were discussed with ward staff and service users at ward meetings prior to the commencement of the data collection. Permission had been granted by the unit managers to enter the premises to undertake the study. However, if the service users or ward staff had objected to the study permission could have been revoked. However following the publication of the homicide report and the review of the service, access to senior managerial and clinical meetings was restricted through the imposition of security measures that prevented the researcher from physically attending meetings. Restricted access to managerial meetings meant that data collection through participant observation was mostly limited to observing activities that took place within the wards and conversations with service users and front line staff. Consent was required to observe meetings and other activities that took place within the unit.

Consent to take part in the study and access to participants are discussed in section 4.12.

4.4.3 The research setting

The study was conducted at an inner city medium secure forensic mental health within the UK. The forensic service was opened in 1987 to provide assessment and short term treatment of mentally disordered offenders. However, since its opening the service had diversified and by 2005 also provided specialist services. At the time of data collection the service comprised of medium secure intensive care, rehabilitation, and women's wards, together with a low secure ward for male service users. Forensic community and a prison in-reach teams were also based at the medium secure unit. However, only inpatient services and resident service users were included within the study. The forensic service formed a directorate within an NHS Mental Health Trust and was situated within the grounds of a Victorian hospital.

4.4.4 A description of the research setting using observational data

The view presented has been formed from an exploration of service documents, the Trust website, observation and interviews with service users and providers. The picture that is presented is one of a service that was under the scrutiny of internal and external bodies as part of a series of reviews that had occurred since a homicide was committed by one of the forensic service users three years prior to the commencement of the study. The homicide was one of a series of incidents that had been covered by the local and national media. Incidents included absconsions from the hospital by high profile offenders, service users absconding and then committing suicide, and also another homicide by a user of the generic mental health services in the Trust. In responding to the recommendations of the reviews the service appeared to become caught up in a defensive pattern of working and an often reactive and unreflective cycle of change. The independent homicide inquiry report was published shortly after the commencement of data collection. The report was highly critical of the service, and stated that it should be shut down. Thus the research was undertaken at a difficult time for the forensic service which was struggling for survival whilst being publicly criticised by the media, and within health and governmental systems criticised by the Trust, Home Office and Strategic Health Authority.

The medium secure unit was located at the edge of the grounds of a Victorian county asylum which was the location for a mental health hospital that provided 780 inpatient beds for a population of more than one million people within an inner city area. Specialised units had been built within the hospital grounds such as those for acute admissions, and rehabilitation. The forensic mental health service was one of those specialist services. The medium secure unit was built in a relatively isolated area of the hospital site, away from all other services. The forensic service originally opened in the late 1980s as a converted ward on the site of an existing psychiatric hospital. In the mid 1990s a purpose built unit was opened on the hospital site, a short distance from the original ward. The service at that time consisted of a 32 bedded medium secure assessment unit which contained two wards.

At the time that the study commenced the forensic service consisted of a 74 bedded inpatient service which was formed of four medium secure wards and one low secure ward, as well as community based and prison mental health services. The community teams were not included in the study. On each ward there were approximately fifteen beds. Three wards were located within the medium secure building and two are located outside of the medium secure unit, in the hospital grounds on the same site. At the commencement of the study the intensive care ward and two acute wards were located in the medium secure building. The low secure and women's services occupied separate stand alone wards. There were no mixed wards and the women are cared for solely on the women's ward (see appendix 2). However the service was re-structured during the period of data collection and the function of the majority of the wards changed (see appendix 2). The function of the medium secure wards in the main building was modified to provide an acute ward with a high dependency unit attached to it, and a ward that provided rehabilitation and sub-acute care. The function of the women's ward remained the same, providing the full spectrum of care from acute admissions to rehabilitation and pre-discharge for female service users. However, the women's ward was re-located to a smaller ward within the main medium secure unit due to low bed occupancy. The low numbers of female service users reflects national statistics that show women to significantly be in a minority within both forensic and criminal justice systems (Rutherford and Duggan 2007). The low secure ward was unaffected by the restructuring process. The ward vacated by the women's service became a rehabilitation and pre-discharge ward for men. Individuals who were believed

to present a lower risk were placed on this ward. The physical security of the ward was considered to meet the medium secure standard. However it was located some distance away from the other secure wards, and so in an emergency help from the other wards would take several minutes to arrive. The entrance to the service is described in detail below.

There was a single point of entry to the medium secure unit via an airlock door. The airlock comprised of two doors with a small space in between. The two doors could not be opened at the same time. To enter the building a person would pass through one door into the airlock, wait for it to lock behind them and then open the next door. The airlock was used with the aim of reducing the risk of an unauthorised individual entering the building or a service user escaping through the main entrance. The receptionist was located in an office which had access to the airlock space via a hatch as well as the reception area that lay beyond the airlock. The receptionist issued keys to members of staff, and checked whether visitors were to be allowed access to the unit. The reception area was essentially a waiting room with locked doors leading off it to corridors that led to the wards, offices, meeting rooms and activity areas. The reception area felt quite unwelcoming, shabby, dull, worn, and unclean. The message conveyed was that of security, rules and dissatisfaction. The formal welcome message was lost in a notice board full of instructions. The reception area created a feeling of powerlessness, where all movements and actions were monitored and decided upon by service providers. The walls of the reception area were painted in cream, with scuff marks and dents in the walls. There were two two-seater sofas facing one another, their patterned covers washed and shrunk, not quite fitting, exposing the cream coloured cushions underneath. There was a coca-cola machine next to the sofas and an internal telephone with a sign next to it telling visitors that the telephone was for staff use only, and that mobile phones should not be used in the reception area. A board bore several notices on pieces of coloured A4 paper. Three security notices were displayed. One colourful notice provided a list of contraband items that could not be taken into the clinic. The sign was illustrated with cheerful clip-art pictures of the banned articles. Alongside the contraband notice was a zero tolerance poster that declared there was a zero tolerance of drugs, alcohol and violence in the service. Next to this is an NHS poster declaring the service a smoke free zone. Beneath the security posters a monochrome A4 printed sheet welcomed visitors to the clinic and stated who the managers of the unit were. There were then two notices for carers' associations. On the reception walls signs had been placed near the door reminding staff to hand

their keys in at the correct hatch. Around a corner, away from the sofas was a small glass fronted wall cabinet that displayed some of the pottery items that had been made by service users in the clinic. A year after the study commenced the walls of the reception area were re-painted cream, the carpet replaced with a dark wooden floor with a light coloured line in the flooring that created a box around the two sofas. A small coffee table was placed between the sofas, and on it complaints leaflets were displayed. Damp bubbles appeared through the fresh paint and new scuff marks peppered the walls.

4.4.5 The clinical pathways within the forensic service

It was difficult at the beginning of the study to find and follow through the pathways of care that service users followed through to discharge. However the re-organisation of the forensic service created a system of users stepping down through the levels of physical and procedural security towards discharge as their levels of risk were assessed to decrease. The system of assigning service users to decreasing levels of security through systems of risk assessment reflects the operation of a risk escalator described by Heyman et al (2004). However, due to small numbers of female service users there was only one women's ward and so female service users did not progress through a step-down ward structure in the same way that male service users did. The single women's ward provided assessment, treatment and rehabilitation for female forensic service users. Thus during their stay within the forensic service female service users needed to build relationships and manage their risk status with one team of service providers. Similarly the low secure service was not affected by the changes, even though there was some movement of service users between the medium and low secure services. Another noticeable outcome was the forensic service being decorated and an overall increase in physical and procedural security. The decoration of the service only entailed the painting of the communal and reception areas and did little to change the atmosphere within the service. However, the increase in security caused consternation by service providers who had to instigate new security procedures which were viewed by some service provider research participants as a punitive measure by unit managers (see section 7.3).

4.4.6 The managerial structure of the forensic service

The forensic service formed a directorate within an NHS Mental Health Trust in an inner city area and as such had a clinical service manager and general manager. However the senior managerial structure within the forensic service was in a state of flux throughout the study period. Following the publication of the homicide report a more senior manager was seconded to the forensic service from another part of the Trust to support the existing managerial structure. The manager then stayed within the service, and eventually became the Forensic Service Director, a newly created post. A lead nurse was then appointed, but after a six month probationary period the nurse's employment was terminated and the lead nurse role was left vacant. Thus there were several attempts to stabilise the service through changing managerial structures. However, the managerial structure did not appear to have stabilised and at the end of data collection with the managerial formation remaining under review.

4.4.7 Clinical structure of the forensic service

Each ward within the service had a ward manager and allocated consultant psychiatrists that shared Multidisciplinary Teams (MDTs) with one another. All of the MDTs had medical representation with a consultant psychiatrist, and varying representation of Specialist Registrars (SPRs), Senior House Officers (SHOs) and staff grade doctors. Occupational Therapists (OTs), psychologists, art therapists and social workers were also MDT members. However the service's resources were limited, and OTs, art therapists and psychologists were members of several teams. Not every team had social worker representation. Nurses were members of the MDT, as well as ward nursing teams. The ward managers, who were all nurses, attended every MDT meeting with different qualified nurses representing the ward nursing team at each meeting. On each ward there were approximately fifteen beds, with a ratio of one member of nursing staff to every three service users per shift. Thus for a typical fifteen bedded ward there were five members of nursing staff per shift. The nursing staff team consisted of qualified nurses, unqualified Health Care Assistants (HCAs) and activity coordinators. Activity coordinators were members of the nursing team, and were a similar grade to HCAs but largely worked with the OTs, organising activities for times when OT staff were not available such as weekends and evenings. For each shift there would be a

minimum of two qualified members of nursing staff, one of whom would take charge, or coordinate the shift.

4.4.8 Ward environments

The ward environments varied greatly by lay out, state of décor and cleanliness. However the differences were most marked between the main unit and the stand alone wards. The décor of the wards as described below were viewed by service providers and users as an indication of status and the ethos of the ward team. Prior to visits by external agencies service providers were observed to encourage service users to tidy their rooms and clean the ward. However, the wards in the main unit seemed to be quite worn and in need of re-decoration. One male patient described their ward as being:

“...like a squat, there is too much noise and a lack of ventilation, it is too hot, the plumbing is blocked... its not like an official government building...”

(Sam, service user: observation)

In contrast, the women’s ward and low secure wards were brightly coloured, and with large open communal areas where all the service users would sit. The service users described the women’s ward in terms of being a home. One service user spoke about being involved in organising and decorating a ward, such as choosing the colours of the paint and the furniture that was ordered.

[the ward manager] came up to us and said you know that er, what colour scheme we would like and, yeah we had an input he did ask us and we felt like it, you know belonged to us here. You know?

(Ray, service user: interview)

Therefore, beyond the differences in function there was a great difference in appearance and ethos of the outlying wards and those inside the main unit. Service users' resident within the outlying wards described being more involved with decision making regarding their living environment.

4.5 The characteristics of service user and provider research participants

Demographic information was only collected by the researcher for people participating in formal interviews (see appendix 1). Demographic information regarding the workforce and service users was not made available by the service. Therefore the description of attributes of the service user and provider is drawn from the field notes of the researcher. The service users and providers had diverse ethnic backgrounds. The ward based nurses were predominantly Black African. Non-nursing members of the MDT were mostly white, with English, Australian, and European ethnicities.

Service users were ethnically very diverse, identifying themselves as Black British, Black African, Asian, Arab and White English. The mixed ethnicity of the forensic service users reflected the characteristics of population of secure forensic services (Rutherford and Duggan 2007). The catchment area of the service was largely inner city, although the service also covered parts of the suburbs. Wealthy as well as impoverished areas within the city were covered by the service. The population of the catchment area of the service is relatively young, over half the population being between 20 and 44 years old. However, only 22% of people from the catchment area are from minority ethnic backgrounds (PCT statistics), thus indicating an over representation of minority ethnic groups within the residents of the forensic service. This is consistent with an over representation of ethnic minorities within the prison and forensic mental health services in England and Wales (Rutherford and Duggan 2007). The forensic service users were predominantly between the ages of 25-50 years, and male. The gender and age of service users was in part dictated by the admissions policy of the forensic service, which provided care for the adult age group of 18-65 years old. The majority of service users had committed an offence and entered the forensic service from court, and high secure or prison services.

A marked stratification of ethnicity within the organisational hierarchy was observed. The ward based nurses, and support staff, e.g. housekeepers and domestics, were predominantly Black and African. The other health care professionals within the MDT are mostly white, with English, Australian, African and European backgrounds. Senior managers were mostly white. Therefore, the issues surrounding ethnicity are different at different levels of the hierarchy. For example, at ward level, black and ethnic minority groups formed the majority of service users and front line staff and during interviews white service user and provider participants often expressed feeling excluded and disempowered by the majority BME group (see results chapter). However the BME group then feels excluded by the senior managers who are predominantly white, something which was expressed in an anonymous letter sent by staff to high ranking managers and the press. Thus the racial tensions within the service were complex and differed according to an individual's positioning within the organisation.

4.6 Events which affected the conditions within the research site

Shortly after the period of data collection had commenced a series of events occurred within the service that affected the methodology and methods used. These events are described below, and will be referred to throughout the thesis. The reports of the incidents discussed are not referenced in order to attempt to preserve the anonymity of the research site.

A damning homicide inquiry report was published soon after the data had started to be collected. The report was highly critical of the service and called for it to be closed. The report attracted negative media attention both locally and nationally. The service came under the scrutiny of the Department of Health and Home Office. Internal and external reviews of the service took place and physical systems of security were increased. Data collection was allowed to continue. However, access to senior management team meetings was restricted, and the atmosphere of the service changed to become more defensive, and focussed on protecting the service and protecting jobs. Interim measures put in place by the service whilst the review took place included suspending all service users' leave, and suspending the consultant who was named in the inquiry

report from clinical practice despite the report being published nearly two years after the event. The intensive care ward was closed and the service restructured.

Not long after the homicide inquiry report was published another serious incident occurred which compounded the problems that the service providers encountered. Two 'high profile' patients escaped from the intensive care ward in the medium secure unit using keys that they had obtained from a member of the nursing staff. Following the escape and subsequent discussion with the Home Office, the medium secure unit was closed to all admissions. High profile patients and patients who were assessed as posing a high risk to the public were moved from the unit and relocated to other NHS and private medium secure units.

Thus although the research site studied was fairly typical of inner city medium secure forensic mental health services within the UK, the social conditions within the research site were specific to the forensic service studied. These conditions were formed through the external criticism and scrutiny from the Home office, media and the Trust together with the changes made to the clinical pathways, structure and function of the service.

4.7 Sampling strategy

Open sampling was initially employed, whereby openness rather than specificity guides the collection of data (Strauss and Corbin 1990). Thus at the early stages of the study sampling was kept open to all possibilities of data collection to provide the greatest opportunity for the discovery of concepts (Strauss and Corbin 1990). During the process of open sampling, the structure of the interviews and observation were in part determined by provisional concepts derived from the preliminary literature review and the researchers' previous experience of working within forensic mental health care. These concepts included the balance between autonomy and safety, and the containment of risk. Constant comparison techniques were employed alongside data collection and sampling as part of the cycle of design, data collection and analysis. The themes that emerged from the data informed both the interview schedule and sampling. Thus, as the study progressed, open sampling was replaced by theoretical

sampling which enabled concepts which had theoretical relevance to be explored through gathering data that enabled new comparisons to be made (Strauss and Corbin 1990; Dey 1999). The research took place in one research site, which limited the range of theoretical sampling. However, sampling took place across the service, geographically as well as across service provider and user groups. Therefore similarities and contrasts were generated within the data which enabled comparative techniques to be fully employed. As the analysis progressed further data was collected to refine the core category of the regulation of communication. Horizontal and hierarchical social structures such as social groupings were also explored to dimensionalise the data. Sampling was discontinued when theoretical saturation was achieved whereby the categories that were identified were considered to be stable and no further properties, relationships or categories emerged from the data analysis (Dey 1999). In the present study once the category of the regulation of communication had emerged strongly from the data analysis theoretical sampling was employed to explore the properties and variations within the category, and its relationships with other categories, including the management of risk status. Once the relationship between the regulation of communication and the management of risk status had been established and depth and variation in the categories discovered, the researcher determined that theoretical sampling had been achieved (Corbin and Strauss 2008).

4.8 Sampling for data collection by formal interview

In the first stage of the study, the identification of key informants for interview was initially driven by the service structure and focussed upon high ranking unit managers and clinicians. High ranking members of the organisation were chosen for interview in order that the official organisational structure may be mapped, relationships with individuals in powerful positions developed and permissions for access reaffirmed. Indeed Allbutt and Masters (2010) note that building a trusting relationship with gate-keeping participants is crucial to undertaking ethnographic research. Each individual identified was sent an email invitation to participate in the study. The email included an information sheet and a consent form. The email was then followed up with a phone call to make an appointment for the interview. All of the high ranking members of the organisation who were approached agreed to be interviewed. However, one interview did not take place as the participant had problems identifying a time that they were

available for interview, and then abruptly left the service. Interviews took place at the research site.

As the study progressed and the researcher developed her sensitivity to the social structure of the organisation, informants who held low positions within the official organisational hierarchy but who were influential within the organisation were identified, invited to participate and interviewed. Informants were identified through recommendation by other informants and observation. Once the researcher was embedded within the research site, service user and provider participants were approached in person and appointments made for interviews. Flexibility was required for arranging interviews with ward based staff as, due to their work load, they were often unable to find an hour during their shift that could be used for an interview and interviews were regularly rescheduled.

4.8.1 Sampling for the observation of activities within the forensic service

Access to the ward areas and activities for observation was largely negotiated with service providers and users and planned in advance. Thus the researcher observed activities occurring on wards that she was given access to. Obtaining consent to observe activities that took place within the research site is discussed in section 4.12. As with formal interviews open sampling was initially used and then theoretical sampling. However, through out the period of data collection, observation was often an opportunistic process with the researcher taking any opportunity available to observe activities and meetings that she would not normally be able to access.

4.8.2 Exclusion criteria

Insufficient funds were available to provide interpreters for participants who did not understand written or verbal English. Therefore it was decided that all individuals who could not communicate in English would be excluded from the study. However, all service users and providers were able to communicate effectively in English. Therefore no-one was excluded from the study on the grounds of language.

4.8.3 Limitations in sampling

As the data collection progressed sampling was restricted directly and indirectly by research participants, in particular high ranking unit managers. The organisational response to the publication of a damning homicide inquiry report and two serious untoward incidents in regards to the research was to limit the researcher's access to managerial meetings and to prevent the feedback and discussion of the research findings with the research participants see section 4.9. Therefore additional data regarding the phenomena of the regulation of communication could not be obtained and sampling was largely limited to ward based activities and staff. However, observations and memos regarding the organisational response to the incidents and inquiry report were included in the data analysis which strengthened the study through the inclusion of broader structural conditions originating from outside the organisation.

The data collection was also limited by the researcher's ethnic back ground. The researcher's ethnic back ground is white and British. She was unable to gain the confidence of groups that had formed according to the members' ethnicity or language spoken, as they were largely formed by people who were black and African. African languages were often spoken by group members. These languages could not be understood by the researcher. Furthermore groups in which the researcher was accepted and became a member of often exerted pressure for the researcher not to record information that was shared outside of formal organisational systems. Therefore some data was used to improve the theoretical sensitivity of the researcher but was not included in the actual data analysis.

The working patterns of the researcher also limited the sampling and collection of data (Van Maanen 1988). The researcher did not have set days or times for data collection, and the days of the week that the researcher spent in the field varied. A purposive approach was taken, with the researcher arranging to spend time observing activities occurring in the unit when research participants were available for interview, or when planned activities such as ward meetings were taking place. Data collection took place during week days and weekends. The timings of the visits varied from early mornings to evenings day times. However, the observation mostly occurred between the hours of

9-5, as this fitted in with existing ward patterns of handovers to MDT members, and the researcher's availability. Late evening and night shifts were not observed, largely as the researcher was unavailable, but also due to the lack of planned activities.

4.8.4 Problems with access for observation

Permission to attend meetings had to be agreed on each occasion, and often the researcher was not informed of when or where meetings or activities would be held. Also, because of physical security measures, such as locked doors, the researcher could not physically attend certain activities within the forensic service. In consequence, the sampling approach particularly for observations could not be as broad ranging as originally planned. The difficulties encountered by the researcher were often overcome through the development of good relationships with research participants who would then allow the researcher to accompany them to meetings and activities. Thus the physical and social structure of the organisation affected access to opportunities for data collection.

4.9 Methods of data collection

The methods used for data collection are discussed below. Firstly the use of formal interviews is discussed, followed by the ethnographic methods of participant observation and informal interview.

4.9.1 Formal interviews

Formal interviews were undertaken as they enabled the researcher to

...uncover, ascertain and qualify the meanings that others hold for objects in their life worlds and the ways in which people go about accomplishing their activities in practice... (Prus 1996)

Thus interviews enabled the researcher to gain familiarity with the research site and develop her understanding of the meanings that the research participants had for the activities with which they engaged during their everyday life within the forensic service. It was expected that service managers and clinical leaders would be formally interviewed prior to commencing data collection on the wards. However managers proved difficult to contact, and had only limited time available for interview. Therefore, due to time constraints interviews had to continue into the planned period of participant observation. However, interviewing participants alongside participant observation enabled emergent themes to be explored with research participants. Follow-up interviews were conducted with unit managers and clinicians who had been interviewed at the beginning of the study. Formal interviews fitted with the working schedule of many service providers (e.g.: non-ward based members of the MDT) and so could be used more readily for data collection than informal conversations. Formal interviews were also undertaken with members of the ward staff from the intensive care ward which was closed before participant observation could take place.

Twenty six interviews were undertaken, twenty four interviews with service providers and two with service users. Only two service users were interviewed due to difficulties in maintaining confidentiality and also the way in which service user participants responded to being interviewed formally, see discussion below and also section 4.12. The average length of interview was 40 minutes; the shortest interview was 25 minutes and the longest 90 minutes. The duration of the interview was dependent on the participant's other commitments, and often interviews were interrupted due to clinical or managerial need. Basic demographic information was gathered from individuals that participated with the formal interviews. This information provides an indication of who was willing to be interviewed for the study. The demographic information for the participants who were formally interviewed is outlined in appendix one. The interviews were lightly structured and conversational in nature in order to enable an in-depth discussion of research participants' experiences of forensic mental health care. Constant comparative technique was employed and the structure of subsequent interviews was informed by the analysis of previous interviews and observational data. The development of classifications and categories then fed into the process of theoretical sampling. Participants were invited to describe and reflect upon scenarios or examples from their practice in order to elicit their interpretation of past events or

current procedures (Silverman 2000). Several participants were interviewed informally as well as formally. Of these participants, many responded differently to being formally interviewed rather than having an informal discussion. Although, during formal interviews several participants presented a sanitised view of the service, for others it was an opportunity to air their views in a safe and open context with the surety of confidentiality and anonymity.

Formal interviews were undertaken in a private room within the unit. All except one of the interviews were digitally recorded and fully transcribed. One interviewee did not wish to be recorded and so notes were taken during the interview and more fully written up after the interview. The Interviewee was provided with a copy of the written account of the interview for verification purposes. Managers and clinicians (i.e.: doctors, psychologists and therapists) were mostly interviewed in their office. For ward staff and service users interviews took place in interview rooms in the ward setting. The interview rooms provided a formal clinical context familiar to both interviewer and interviewee. Often it appeared that both researcher and participant slipped into re-enacting roles of user and health care professional or high and low ranking members of the organisation in manner that did not occur during participant observation. Therefore the location of the interview greatly affected how reality was constructed and interpreted by both the interviewee and interviewer (Herzog 2005). However, due to difficulties in relation to service users' leave status and ward programme an alternative venue could not readily be found. Therefore, informal rather than formal interviews were employed with service users in the ward setting and formal interviews were only used with ward based staff if it was not possible to explore emergent concepts with them in informal conversations. The researcher made notes of her reflections on interviews with service providers (see section 4.7.4). Notes taken following interviews with non-ward based managers revealed that these interviews often left the researcher feeling that the managers needed more support from their colleagues. During formal interviews managers often gave an impression that they were in quite an isolated position within the organisation. Some managers discussed the problems that they were encountering with the service and sought advice and support from the researcher.

Therefore service user and provider research participants responded in different ways to formal interviews. The research participants' reactions may have in part, been influenced by how they perceived the researcher's role and status. The environment for the interviews to take place in and the participants' personal needs to safely express

their views and feelings might also have affected their responses to the researcher's questions (Charmaz 2006). Often different perspectives were provided on the same issue by the same informant in informal interview, observation and formal interview, thus indicating how communications were shaped by their social context.

4.9.2 Data collection by participant observation

Observation involves the researcher being a witness to events, undertaking informal interviews and also capturing written information such as diaries, or documents which are available within the field of research (Prus 1996). In the present study the researcher observed activities and conducted informal interviews within the field over a period of eighteen months. During this period of time, approximately four hundred hours of observation were undertaken. The researcher's role as a participant observer is discussed in section 4.12. As with formal interviews data collection was guided initially by open and then theoretical sampling, with specific data gathered from the field used to elaborate themes that emerged from the process of constant comparison. For example informal daily activities such as ward cleaning were observed to gather further information on emergent themes such as the ward as a family, with service users referring to nurses as 'auntie' or 'dad' whilst interacting informally with one another. However, the researcher was not able to freely follow theoretical sampling and explore emergent themes in different conditions and with informants across the whole of the forensic service. Access to each ward had to be negotiated with the service users and providers and set periods of time were allocated to specific wards so that the ward staff and service users knew when to expect the researcher to arrive. However, the observational work was also opportunistic, with the researcher attending events and meetings when she was able to.

Observational research often requires the researcher to take a passive role in relation to other actors within the research site and also to attempt to be as unobtrusive as possible (Murphy and Dingwall 2007). However, for participant observation the observer undertakes an active role in order to fit into the research field (Prus 1996). Hammersley and Atkinson (1995:1) describe participant observation as the researcher participating 'overtly or covertly in peoples' daily lives for an extended period of time,

watching what happens, listening to what is said asking questions'. In the present study, participant observation was undertaken overtly and with the consent of the participants. However, as the researcher spent prolonged periods of time in the field and observed a range of activities in relatively public areas consent was problematic. Consent in regards to participant observation is discussed in section 4.12.7.

Participant observation was essential to data collection as it enabled the researcher to become closer to the lived experiences of participants (Hammersley and Atkinson 1995). Thus, the researcher sought to use participant observation to gain insights into how service users and providers socially constructed their world by spending time with the research participants and engaging with their day to day activities (Cheek 2000).

Participant observation fits well with a symbolic interactionist approach which requires the researcher to adopt a reflexive approach. Through describing and analysing their own experiences the researcher may establish how their own experiences are similar or different to that of the participant (Prus 1996) (see section 4.9. 8 for a discussion of the researcher's relationship with the field). Thus rather than merely observing and recording action the researcher undertakes the role of the actor and sees the world from their point of view (Blumer 1969).

4.9.3 Informal interviews undertaken during participant observation

Spontaneous informal conversations commonly form part of participant observation (Hammersley and Atkinson 1995). In the present study these informal interviews are distinguished from formal interviews as they were situated in the participant's natural environment and were not audio-recorded.

The use of informal interviews was particularly important for capturing data from ward nursing staff and service users as problems emerged with formal Interviews. For example, due to ward routines and safety issues the nurse in charge of the ward had to be informed of the interview and a time and venue for interviews with service users and ward based service providers. Thus the anonymity of participants was potentially

compromised. Furthermore in the formal setting of an interview room the researcher and service users returned to their roles of service provider and user, echoing the power dynamic that existed in the service. Service users attended to provide sanitised accounts of their experiences of forensic mental health care, and presented themselves in terms of what they thought might be required in order to be eligible for discharge. Similarly ward nursing often described a text book version of forensic mental health care which did not reflect the practice that had been observed. This behaviour by the ward nursing staff during interviews possibly reflected a lack of trust in the researcher to maintain anonymity and confidentiality. Furthermore the researcher had previously been a manager within the service. Thus the researcher and research participant may have been unconsciously engaging in the dynamic of a manager asking a low grade member of staff about their practice, who then regulated their communication. The low grade staff suppressed reports of failure or problems and presented a positive picture of the service.

Therefore data regarding the experiences of ward based nursing staff and service users were largely collected through ethnographic methods of observation and spontaneous informal interviews in the field, rather than formal interview.

4.9.4 Recording data: the use of field notes

In order for observation to be meaningful the researcher must be able to achieve clear and accurate representations of phenomena as participants experience them, and the inferences that the researcher has made (Prus 1996). Field notes written by the researcher contained descriptions of events that were observed and accounts of conversations held with research participants. Therefore, for the present study most field notes were written whilst the researcher was in the field. On occasions when memo writing whilst in the field was not possible the researcher recorded her observations shortly after completing a period of observation. Informal interviews and conversations were recorded in written field notes. Memos relating to the process of analysis, theoretical and operational notes were written into the field notes and bracketed off.

The researcher attempted to take notes in a manner that was broadly congruent with the social setting that was being observed (Hammersley and Atkinson 1995). Notes could be written during ward rounds and case conferences as the other members of the team were each writing into their own notes. Indeed it was less conspicuous and felt less intrusive to be writing notes rather than just sitting and observing the meetings. Notes could also be made whilst the researcher spent time observing activities on the women's ward. The researcher had been given a key for the ward, and so could enter interview rooms where notes could be written away from the research participants. The researcher had also informed staff and service users that she was a registered nurse. She was then treated as a quasi-member of nursing staff, being asked to answer the door or look after the ward during staff team meetings. Nursing staff carried clipboards and noted where the women were every 5-30 minutes. Taking notes was therefore an accepted nursing activity on that ward and so the researcher was often able to sit and make notes openly. However, whilst observing the male wards the researcher was not allowed to have a set of keys. Not having keys meant that the researcher spent more time with the service user rather than provider group. However, it proved more difficult to make notes contemporaneously as interview rooms could not be accessed. Furthermore ward staff did not carry clip boards and completed their records in the nursing office. Therefore it would have been incongruous for the researcher to openly write notes whilst spending time on the ward.

An inconspicuous approach to note taking was taken by the researcher in order to be sensitive to the research environment. Mental health service users were subject to constant observation by service providers, with users' locations and behaviours recorded a minimum of once an hour. Thus the additional observations undertaken for the study needed to be managed so that they were not overly intrusive and service users did not feel threatened (Hammersley and Atkinson 1995). This unobtrusive approach to note taking follows the approach taken by previous ethnographic studies in health care settings (Allbutt and Masters 2010; Johansson et al 2006; Quirk et al 2006).

However, not taking notes in the presence of participants may be viewed as deceptive (Mulhall 2003). Participants may not have been fully aware that their conversations and behaviours were being recorded and used as data by the researcher. To address this problem the researcher often reminded the participants that she was observing their activities. The problem of consent is discussed in more detail in section 4.13.

4.9.5 The researcher as participant observer: roles assumed and assigned

Observational methods can be classified according to their degree of formal structure and level of researcher participation (Robson 1993). Gold (1958) categorised the researcher's role when undertaking participant observation as complete participant, participant as observer, observer as participant and complete observer. A complete participant would be one where the researcher was undertaking covert observation, their research activities concealed. The complete observer would have no contact with the people that they are observing (Atkinson and Hammersley 2006). It was expected that the researcher would adopt the role of observer as participant whereby the researcher observes through participating in activities, but the primary role of the researcher as observer is made clear to the participants at the commencement of the study (Robson 1993). However, the role of researcher was not one with which many of the participants were familiar with, and so the researcher was assigned roles with varying degrees of participation by research participants. The researcher was mindful of the impact of role perception on data collection and analysis and so took careful notes of how the participants were relating to her and also recorded her reflections on the roles that she performed whilst in the field.

As the research progressed, dependent on the area being observed, the researcher's role fluctuated between participant as observer and observer as participant. Thus researcher's degree of immersion in the field differed according to the social context of the observation. For example, during the observation of ward activities the researcher acted as a participant observer, often taking on the role of a member of the nursing team. However, when the researcher was allowed to observe management meetings within the service she took a passive, observational role as she did not wish to jeopardise access to meetings or her relationship with senior unit managers. The variation in the researcher's role and behaviour reflects how she adapted to meet the expectations of participants in the field. Murphy and Dingwall (2007) do not use the term participant, preferring the term hosts, as it maintains the researchers' role as a guest in another person's setting. For service providers this was the setting where they were employed. However, service users may be resident within the service for many years. The researcher was conscious that she was entering service users' home and made every effort to be respectful of service users' and providers' social rules and

boundaries. As a guest, the researcher needed to follow expectations of proper behaviour in order to maintain access to the research site. Each ward community viewed the role of the researcher differently. Ward groups expected a different level of participation and conduct from the researcher, which the researcher needed to be sensitive to.

4.9.6 Role assignment

The role of the researcher was largely determined by her relationship with the service provider research participants. Access given to the researcher to service provider only areas often aligned the researcher with the nursing staff for service providers as well as service users. However, service user research participants also related to the researcher as an outside witness who could record and communicate their frustrations with the forensic service. As described above service providers chose whether to allow the researcher to hold keys, and so have the independence to be a participant observer and act in the role of a nurse. As a registered nurse the researcher was able to undertake the role of service provider comfortably. However it was much more problematic to take on the role of a service user, due to differences in gender between the researcher and service user participants, the researcher's back ground as a nurse and ultimately the researcher being a free citizen, whilst the service users were all detained under the Mental Health Act (1983). The service users were separated by sex, and the majority of service users were male. There was only one women's ward within the service; the remaining four wards were occupied by male service users. Therefore whilst spending time on the majority of the wards the researcher could not attempt to take on many of the aspects of the service user role. These differences were marked by divisions in simple activities such as using the bathroom. On wards for male service users there were no unlocked toilet facilities for women, and so the researcher needed to use the staff facilities, thus reinforcing the division between the researcher and service user participants. Also in the majority of the areas being observed there were service user and service provider participants present. It was not possible for the researcher to take on the role of service user and provider simultaneously. Therefore, the researcher was largely aligned with service providers by the participants and the structures of the organisation. The researcher was mindful that this alignment might result in impaired relationships with service users and the researcher identifying with the service provider perspective (Hammersley and Atkinson 1995).

During the observation of one of the male wards the researcher was given a key for the ward doors. As she did not have a key the researcher was unable to move freely within the ward and so could not fully participate as a member of the nursing staff. However, she could not align herself with the service users as the researcher was female and they were male. The researcher could not use many of the service user facilities such as the bathroom or toilet, nor attend therapy sessions. Therapy sessions took place on an individual basis or in closed groups, which were inaccessible to non-members. Thus, the researcher occupied a marginal role, spending the majority of her time sitting in ward areas with services users. However, service users seemed to relate to the researcher's experience of being disenfranchised within the service and her relative powerlessness. If the nursing staff ignored the researcher or were rude towards her, service users would make comments such as

now you see what it is like here (Carl, service user: observation)

Therefore, although the researcher could not truly experience the role of a service user, the service users indicated when the experiences of the researcher overlapped with their own. Also, due to the researcher's sustained proximity with service users, she was able to develop trusting relationships with service user research participants and address any concerns they had regarding her quasi-nursing role, and the potential for exploitation (see section 4.12). Once relationships had been built with service users the researcher was able to have informal conversations with them, exploring their experiences and validating her interpretations of phenomena observed.

4.9.7 The researcher's relationship to the research site

The researcher had previously worked at the unit as a ward manager, which was advantageous in obtaining access to the clinic, but at times blurred boundaries in relation to the researcher's role of participant observer. Several members of staff at the research site had worked with the researcher, and a small number of service users were also known to her. The researcher had left the service on good terms, and her previous working relationships with service providers and users often meant that she could more easily gain access to observe meetings and activities within the service.

However, some tensions existed between the researcher and service providers whom she had managed in the past and had since been promoted to high ranking positions within the organisation. The researcher addressed these tensions by verbalising and demonstrating that her role within the service was now subordinate to these providers.

Due to the researcher's existing knowledge of the service it was often difficult for her to identify taken for granted assumptions such as the power differentials within a ward setting between different health care professionals. The researcher also experienced tensions between her role as a researcher and as a registered health care professional. Often the researcher wished to intervene in clinical practice situations which she felt to be unsafe, such as patients who were meant to be being observed constantly by nursing staff being left unobserved or with an inexperienced student nurse. This is a tension known to be commonly experienced by nurse researchers (Baillie 1995). The researcher was aware that if she intervened that she could be viewed negatively by service provider participants. To raise the issue of poor nursing practice was to criticise the ward staff, and so potentially lose the cooperation of the nursing team. The researcher was conscious that front line staff might be suspicious of her motivations for observing their activities, believing that she might report poor practice to unit managers. Therefore the researcher spent time reassuring ward staff that this was not the case and reminding them of the assurances of confidentiality given when they consented to participate in the study; that only concerns that harm would be caused to a user of provider would be reported. The researcher addressed the tensions that she experienced between her roles of nurse and researcher through supervision with research and clinical advisors. During the study the researcher did not break confidentiality and report problems with practice. The ethical issues relating to confidentiality and decision making are discussed in section 4.12.

Research participants' reactions to the researcher differed. The researcher tended to be treated as nurse or a confidante by the service users. Service providers either treated the researcher as a nurse who should address problems within the service or as potential whistle blower who needed to be silenced. For example, when a ward round became disorganised, a senior consultant whom the researcher had known in her previous role as nurse manager asked that she sort out [her] colleagues in front of a member of the ward nursing staff. The nurses did not seem to react differently to the researcher following the meeting. However, the researcher was concerned that the

nursing staff could have interpreted the consultant's comments as an indication that she was working with the managers to monitor their practice, and so would be less likely to talk to the researcher or enable her to observe activities taking place within the service. The researcher also became aware that, given the way that some research participants were responding to her, there was a risk of going native in the field. The researcher was aware that she could easily slip into the comfort of familiar ward rules and routines and lose the problematic in the data (Borbasi, Jackson and Wilkes 2005). Thus analysis would be abandoned in favour of participation (Hammersley and Atkinson 1995). An additional risk associated with taking on the role of a nurse manager was losing the trust of service users and ward staff participants, with respect to maintaining their confidentiality. Therefore, the researcher limited her degree of participation in nursing roles, and discussed the process of data collection and field work in supervision meetings with research supervisors and the advisory group. The researcher attempted to maintain a marginal status, developing a good rapport with research participants and yet maintaining sufficient distance to enable an analytic stance to be taken during data collection.

4.9.8 Feedback to research participants and leaving the field

Leaving the field was problematic. Ethnographic research is based on relationships built between the researcher and the host (Murphy and Dingwall 2007). In the present study, strong relationships had been built between the researcher and the research participants. The participants expected that the researcher would give voice to their experiences of a forensic mental health service, during the third phase of the study, the dissemination of the findings of the study and to generate recommendations for the development of forensic mental health services. However, expectations were not met as the management team prevented feedback of the emergent themes from the data to the participants, as they felt that this would be detrimental to the service. A summary of the preliminary findings of the study was produced and distributed to the unit managers. The managers objected to the content of the report. They agreed that the report accurately represented the issues within the unit at the time that the data was collected. However they informed the researcher that they had since initiated a program of change which they believed had addressed the issues highlighted by the report and they did not want the report to open old wounds. The unit was still under

scrutiny from the Home Office and the unit managers felt that an open discussion of problems could threaten the continued functioning of the unit.

Thus the research participants were unable to see the study through to the final stages of analysis and the dissemination of findings. Also the study had little impact on the improvement of care in the service studied. The researcher provided money to each ward that had taken part in the study so that a social activity could be arranged to thank the service users and providers for participating. However, during data collection the service had been restructured which resulted in several users and providers being moved to other wards within the Trust or outside secure facilities. Thus, not all research participants could engage with the social activities arranged. Therefore not all participants could be thanked for their contribution to the study and none could be provided with a research report.

4.9.9 Limitations to observational work

It was planned that observation would be undertaken on each of the five wards, thus encompassing intensive, acute and sub-acute care in the forensic service. However, due to the closure of the intensive care ward and delays in gaining access to other wards in the service, observation could only take place on three of the wards, male rehabilitation, the women's ward and the low secure male ward. Thus the researcher could not observe activities taking place within the higher levels of security. The management of risk status could not be explored within the most restrictive conditions within the service or with service user research participants who had been assessed to present a high risk to other people. Permission was granted to observe a fourth ward, but it was very similar to the rehabilitation ward where observation was already underway and so it was decided not to observe the activities on that ward.

From interviews and informal discussion it was evident that the intensive care ward had developed notoriety within both the service user and provider groups for being an unsafe and unpleasant ward to be on. However it was also seen as a pivotal part of the service where users who were considered to be dangerous could be sent. Service user research participants felt that it was important that the practices on the intensive care

ward were observed, as the service users who were resident were often vulnerable. Unfortunately with the ward closure it was not possible to observe the activities on the intensive care ward. However members of the clinical team for the intensive care ward were formally interviewed.

4.9.10 Case note review

It was planned that a subset of participants from the second stage of the study would be selected for case note review, whereby the accounts of key events relating to risk assessment and management processes in the participants notes would be explored. Agreement was obtained from the consultants and clinical teams for case note review to be undertaken. However, service users were consistently unwilling for the researcher to read their clinical notes. Service users were asked why they did not want their case notes to be reviewed but could not give any reasons, other than that they felt uncomfortable. The participants were not obliged to give reasons for declining, and the researcher found that asking the service users why they wouldn't give permission was difficult as this could be experienced by the research participants as pressurising. Also when refusing to allow access to their notes the service users often physically looked uncomfortable and withdrew from further interaction following the request. The researcher felt as if she was being intrusive and that by forcing the issue of access to their notes that she might lose users' trust and cooperation. Therefore, data collection by case note review was abandoned. However, ward rounds and case conferences where reports were distributed and discussed were observed and so information regarding the formal construction of service users and their care was gathered.

4.9.11 Focus groups

The design of the study included presenting research findings to focus groups of service users and providers. It was hoped that the use of focus groups would enable the researcher's interpretations of the data to be considered within the differing frames of explanation of the various stakeholders (Silverman 2000). However as discussed in section 4.9.9, the researcher was prevented by the unit managers from disseminating

the findings of the study to the research participants. The focus groups could not take place and so the theory generated by the study could not be explored from the perspective of the research participants. Therefore it was difficult to assess the fit of the findings with the participants' experiences and to investigate the usefulness of the findings to develop policy and practice (Corbin and Strauss 2008).

4.10 Data quality

Strauss and Corbin (1998) caution researchers using a qualitative methodology against attempting to meet the standards which are usually used to judge the quality of quantitative research. For example, surface unreliability such as participants expressing conflicting opinions in different social contexts can be highly instructive rather than evidence of poor data quality. It has been recommended that the standards of validity, generalisability and reliability that are applied to positivistic approaches are modified for use with qualitative research to consider credibility, and transferability of concepts (Golafshani 2003; corbin and Strauss 2008). Credibility and transferability will be discussed below in the relation to the present study.

4.10.1 Credibility

Credibility may be described in terms of the findings of a study providing a true representation of the phenomena of interest (Marvasti 2004; Corbin and Strauss 2008). It is acknowledged that the theory being constructed in this study is based upon the interpretation of the researcher. The researcher takes the stance that it is impossible for a researcher to divest themselves of preconceived ideas and enter the field as an inert and objective conduit for research. Therefore the study largely follows a constructivist and interpretive approach. The present study focuses on social interaction and the construction of reality. Data collected is therefore viewed as being created through shared experiences between participants, researcher and the environment (Charmaz and Mitchell 1996, Marvasti 2004). As a co-creator of the meanings and actions that are collected as data, it is important that the researcher is sensitised to the field of research and takes a reflexive approach towards the research process. Further to the fit of the findings of the study with the participant's experiences the story line presented by the study needs to demonstrate context, logic and variation

(Corbin and Strauss 2008). In the present study the findings are contextualised within the functioning of the forensic service and the events that took place that affected the conditions within the field. The storyline of regulating communication in attempt to manage risk status logically flows from the emergence of themes of risk and playing the game. Variation occurs within the findings regarding the manner in which communication was regulated by research participants, and whether the regulation of communication occurred consciously as a means to manage the presentation of self or occurred subconsciously as a response to the individual's social frame.

A further criterion to assess the credibility of a study is the researcher's sensitivity to the participants and the data (Corbin and Strauss 2008). Sensitivity to the field was developed prior to commencing the study through personal connection with past experience as a health care professional working in the service; discussions with current managers of the service and also awareness of key issues for forensic mental health arising from the initial literature review (see section 5.2). Therefore, although the theory was to be inductively developed and grounded in the data, it was felt important that the researcher entered the field with an open mind rather than an empty one (Dey 1999). Alongside field notes, theoretical notes, and memos were made during data collection and analysis, in which the researcher was able to reflect on her experience of studying the forensic service, and record thoughts about analysis and theoretical sampling.

4.10.2 Transferability

A small substantive study using a grounded theory approach such as this study cannot be generalised to a broader population in the same way as a larger quantitative study might. However, it is hoped that the theory generated from the study will have some power to predict and explain phenomena that might arise in the studied population if certain conditions are present. The macro and micro conditions present within the research site are woven into the analysis presented within the results chapters. Macro conditions include the business of the forensic service studied; the location of the service both within the mental health Trust and geographically; and the publication of a damning homicide inquiry report and the subsequent negative media furore. Micro conditions included the responses of the service and research participants to the

inquiry and media reports; the relationships that existed between individuals within the organisation. The detailed description of the conditions in which the study was undertaken is provided in the publication of the findings so that others involved with the provision of forensic service in similar services might be able to find and use elements of the research that are applicable to their local unit. It would be difficult to reproduce the conditions that gave rise to the phenomena captured in the study. However, it is hoped that once the study is published, a broad range of readers will be able to draw upon the descriptions of the research site and phenomena to vicariously experience the events observed and discussed with participants to draw their own conclusions and consider the findings of the research within their own context, thus providing a step towards transferability (Stake 2003)

The generalisability of findings holds great sway with policy makers, who expect expediency in the application of findings and the transferability of recommendations to other settings (Janesick 2003). Therefore, despite being drawn from a different theoretical paradigm, for the research to be influential within the mental health care setting it is important that generalisability in terms of the transferability to other settings is considered. As with many small scale qualitative studies there is a risk that transferability of the theory generated may be limited as the data might reflect the idiosyncrasies of the particular site studied rather than forensic, secure services in general. However, Corbin and Strauss (1990) suggest that hypotheses developed from grounded theory studies may be transferred to similar settings through a high level of abstraction during concept development, the provision of rich detailed descriptions of conditions as well as the phenomena identified and the use of widespread theoretical sampling. It is accepted that the more abstract the core category the more widely applicable the theory generated (Corbin and Strauss 1990). Thus general formal theory is more widely transferable than substantive theory that relates to specific real world situations. The regulation of communication in an attempt to manage risk status is a substantive theory which is grounded in an exploration of human interactions within a forensic mental health service. Therefore the transferability of the theory that emerged from the data analysis is limited to the forensic mental health care setting. However, further research may be undertaken to develop formal theory from the concept of the regulation of communication to manage risk status which may be applied to a wide range of organisational settings beyond forensic mental health care.

4.11 Analytic procedures: data analysis

Analysis within a grounded theory framework is dynamic with data collection and analysis undertaken in recurrent cycles. The direction of the subsequent data collection was grounded in issues that emerged from data analysis. Theory is generated through stages of open, axial and selective coding (Strauss and Corbin 1990; Dey 1999). These phases of coding were employed by the researcher for the thematic analysis of the data. These stages are discussed in more detail below. Atlas.ti, qualitative data analysis software was used to record memos, diagrams and notes as part of the process of analysis. However, Atlas.ti was only used for the initial stages of data analysis, for the labelling of concepts, constant comparison of theoretical concepts and open coding. Abandonment of Atlas.ti was in part due to the difficulty of managing two distinct sets of data arising from interviews and participant observation. To ensure that the analysis remained grounded in the data the researcher used traditional approaches to labelling and ordering data into categories and then exploring the connections and differences that existed between them. This approach enabled the researcher to be fully immersed in the data and so develop an explanatory framework for the phenomena captured through participant observation and interview.

Field notes and transcripts were examined and conceptual labels applied to phenomena. Field notes contained descriptions of observed phenomena and quotations from conversations. However, the researcher also made reflective notes to guide analysis and labelling. These notes were bracketed off from descriptions but were drawn upon for the purposes of conceptual labelling and coding. Samples of transcripts and field notes were examined by both PhD supervisors and discussed in supervision meetings. Supervision supported the researcher with constant comparative analysis, which then informed theoretical sampling. Theoretical sensitivity was enhanced through the challenging of the researcher's assumptions by her supervisors during the process of locating and labelling phenomena within the material collected. In a similar manner open, axial and selective coding was also discussed with research supervisors and the advisory group. Discussions with the supervision team regarding sampling and analysis were particularly important for the researcher during the period of participant observation it enabled her to reflect on her relationship with the field and maintain the problematic whilst collecting data and examining the material, see section 4.12. Feedback and discussion with the supervision team also enabled the

development of interview, observation, memo and field note writing skills. Diagram one below, illustrates the stages of data collection and analysis.

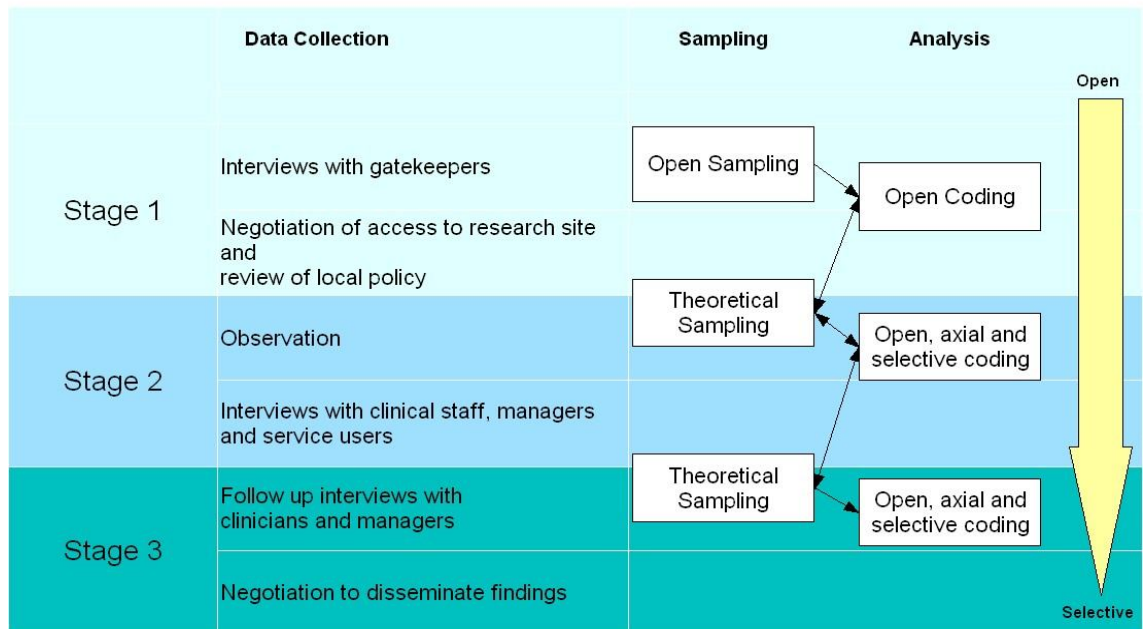


Diagram 1. The stages of data collection and analysis

4.11.1 Open, axial and selective coding

In a grounded theory framework analysis is the interaction between the researcher and the data (Strauss and Corbin 1990). Open, axial and selective coding standardise the process and aid the generation of theory, this process is outlined below.

During open coding the researcher sorted data extracts (e.g. notes of observations and transcribed interview material) into thematic categories. Categories that emerged from the analysis of the data included 'playing the game' and the 'avoidance of blame'. In this way the data was broken down and the story fractured in order to allow an in-depth analysis to be undertaken. Open coding informed theoretical sampling and data was collected to explore and refine the categories that emerged from earlier data. Thus the

interview schedule was amended and participants identified to provide more information regarding the categories identified. Once categories had begun to emerge from the data the researcher commenced axial coding. However open and axial coding were not regarded to be discrete stages of data analysis and occurred simultaneously (Strauss and Corbin 1990). Axial coding is where the researcher begins to fit the pieces of the data puzzle together (Strauss and Corbin 1990: 229). During axial coding the data that had been fractured during the process of labelling and conceptual categorisation began to be reassembled by the researcher into an explanatory framework for the phenomena described. The properties of each thematic category were explored and dimensionalised and relationships were identified between categories and sub categories. The relationship between the regulation of communication and risk was explored, which prompted additional data gathering in different social conditions to enable the researcher to dimensionalise the categories. For example, with service user research participants the relationship between their regulations of communication to try to manage their risk status was explored within the context of risk status being defined by their peers or clinical team. Thus axial coding enabled the researcher to hone her understanding of the phenomena and informed the development of an explanatory scheme. During this process the researcher reflected on her understandings of the phenomena and, as the analysis developed, wrote memos of her interpretations of the data and how connections were made between categories.

4.11.2 Selective coding

Selective coding is the final stage of analysis. Sub-categories are organised in relation to one over-arching category, and additional information is sought to ratify categories or concepts. The seeking of additional information to confirm or challenge the core category was problematic in the present study as the managers of the research site had prevented the researcher undertaking focus groups with service provider and user participants, and had restricted access to the research site. However additional formal interviews were undertaken with clinicians and managers during the process, which focussed on the story line of regulation of communication to try to manage risk status.

From the analysis of the data the regulation of communication was found to be the core category which validated other categories and the connections between them. (Strauss and Corbin 1990). A core category must be central, stable, complex integrative, powerful and highly variable (Dey 1999:111). The regulation of communication was found to satisfy these requirements, presenting as a recurrent pattern in the data which was connected to other categories and varied according to changes in the social conditions in the field. Also variation was found between cases within the data existed, with some research participants deliberately regulating their communication to manage their risk status, whilst others denied or were unaware that they modified communications according to their social context. The regulation of communication was strongly linked to the management of risk status and was observed to vary according to the social environment of the research site. A diagram was generated to demonstrate the connections between the main categories of the regulation of communication, the management of risk status and self-forming groups (see section 8.1).

4.12 Ethical issues

This section will provide a critical of the ethical issues that were both addressed within the development of the research design and those that emerged as the study progressed.

Anticipated ethical issues surrounding data collection, data storage and the dissemination of findings were addressed within the research protocol that was approved by the NHS local research ethics committee. Ethical issues incorporated with the ethical approval granted by the LREC included achieving informed consent in relation to participant observation, ensuring that the research site remained anonymous and the establishment of steps to be taken if poor practice was identified. In response to local research ethic committee's (LREC) guidance information sheets and consent forms were created using the standard template provided by the LREC. The LREC also stipulated that the data was to be made anonymous, securely stored and destroyed once the analysis was complete. However, ethical issues arose during the collection and analysis of the data that could not anticipated or fully addressed during the process of seeking ethical approval. It has been recognised that due to the nature of participant observation, with the researcher spending extended periods of time at the research site

it is impossible to envisage all ethical issues that will arise when undertaking an observational study (Murphy and Dingwall 2007). The researcher addressed unexpected ethical issues that emerged during the course of the study through seeking the advice of her research supervisors, clinical supervisor and advisory team. Ethical concerns were debated by drawing upon professional practice and research guidelines together with Beauchamp and Childress' four principles of biomedical ethics; respect for autonomy, non-maleficence, beneficence, and justice (Beauchamp and Childress 2001). Ethical issues that emerged during the course of the study are discussed below. The issues concern risks to the researcher, exploitation, confidentiality, anonymity and dissemination and consent.

4.12.1 Risk to the researcher

Risks to the researcher were considered at the stage of seeking ethical approval, and systems were put in place whereby the researcher could seek clinical or research support and advice. The researcher was an experienced nurse who had previously worked within the forensic service, and so she expected that she would be able to manage day to day risks to which was exposed during data collection. However, as the data collection progressed it was evident that the researcher was not being given information by service providers regarding risks to her physical safety whilst she was observing clinical areas. This information largely concerned service users and whether they were considered by their clinical teams to pose a risk to others. The researcher often discovered that she may be at risk through observing clinical meetings or informal conversations between service providers. Furthermore as the study progressed the researcher became aware that she did not have up to date skills or knowledge of the service to manage violence and aggression. The researcher's role as a nurse and her familiarity with the research site led her to be over confident about her ability to maintain her own safety. Therefore roles assumed by the researcher affected her personal safety as well as her access to the research site and the process of data collection. Once aware that she was not being informed of risks to her physical safety the researcher requested a handover from nursing staff when she entered the clinical areas and organised her periods of observation to coincide with team meetings.

4.12.2 Exploitation

The potential to inadvertently exploit research participants, for the researcher's gain was a concern throughout the study. The study being undertaken as part of the researcher's doctoral work was explicit within the information provided to the participants. However, service users occupied a relatively powerless position and so were vulnerable to being used for the researcher's gain, to get a doctorate and further her career (Atkinson and Hammersley 2006). One service user participant, Martin, interrupted my discussion with other service user participants to warn them that they were being exploited.

Don't speak to her, for her it's like you doing your homework....they come and talk to us and nothing ever changes...its pointless nothing ever changes....

(Martin, service user)

Martin reminded the service users that they had not benefited from the research previously undertaken. Martin had been let down, he had expected that would benefit from the research, but nothing had changed. In likening data collection to doing homework he highlighted the limitations of the study together with my personal motivations. I responded by agreeing with the limitations of the research and that I had a vested interest in undertaking the research, to obtain a PhD. In line with my belief at the time, I gave assurance that the research findings would be fed back to senior managers, and that it might influence service provision. Thus I chose to be as open as possible and realistic about the limitations of the study with participants.

However, concerns of exploitation arose again when the feedback of findings to the research participants was prevented. Service user and provider participants were not given information regarding the study and so the potential for the findings to benefit the participants greatly reduced. Information was given to the senior managers. However, further dissemination was blocked as it was felt that issues raised had already been addressed and to share the findings of the study would be potentially detrimental to the

service. The needs of the service conflicted with those of the research participants. It would seem that the research participants would not benefit directly from the research, and so Martin's accusation that I wouldn't help them seemed to be true. I felt that I had let down the participants and was unable to tell them why without the risk of losing access.

Becker (1957) advises researchers to consider which side they are on and which side they appear to be on. In this instance the conflict between the need to provide a voice for service users and to maintain a relationship with service providers and complete the study was resolved by the researcher not feeding back the findings of the study to the participants. In this way the researcher seemed to declare which side she was on. However, as with organisational and cultural silencing the researcher deciding not to feed back results to the participants indicated where the power lay in the relationship between providers, users and the researcher. Furthermore as with Sherriff's study of cultural silencing (2000) the researcher was left with uncomfortable feelings regarding a breached contract with participants that she could not resolve. A possibility for future resolution is for the researcher to wait until the managers within the unit feel that sufficient time has passed for the participants' stories to be fed back to current users and providers. Therefore although participants were not directly helped by the research or given a voice, they may influence practice in the future.

Benefits to the participants associated with engaging with the process of research also need to be recognised (Sherriff 2000). The researcher was aware that she was using ward nursing staff time so she assisted service providers when she could, which resulted in further immersion within the world of the service provider. For example if the researcher had keys for the ward and a service user was waiting for a door to be opened or to be given an item such as a towel she would undertake the task, so that the service provider was relieved of work and the user did not have to wait. The researcher also brought food which the participants jokingly referred to as bribes, perhaps indicating that trust and boundaries within the relationship between researcher and participant were uncertain. However, as the research progressed and the researcher became more integrated into the service she found that the service providers would draw on her academic and professional knowledge and that the service users would treat her as a visitor and ask about life outside of the unit. Thus for service users, many of whom did not receive visitors the researcher became a

connection with the outside world. Therefore there were benefits for the research participants as well as costs. These benefits may be difficult to verify as they were largely unintentional and arose from the presence of the researcher and the process of data collection. Therefore it is difficult to ascertain if the research participants were exploited for the study (Hammersley and Atkinson 1995).

4.12.3 Anonymity and confidentiality

The context of the ethnographic research makes anonymity problematic, as rich description may result in the identity of participants being revealed (Murphy and Dingwall 2003). Indeed Van Den Hoonaard (2003:141) goes as far as to say that anonymity is a virtually unachievable goal in ethnographic and qualitative research. Problems with anonymity arise in the present study due to the research site being easily identifiable, the small number of participants and the sampling technique that was used. Participants were known to one another, and so could possibly identify each other from quotations that had been made anonymous by the researcher. Specific language that participants used during interviews could result in their identity being inadvertently revealed even when names and characteristics of the participant have been changed (Van Den Hoonaard 2003). Furthermore due to the events that occurred in the field during the data collection the research site could possibly be identified by people working for other forensic mental health services. If identified, it is conceivable that the service users and providers who participated in the study could be subject to negative consequences in relation to their treatment or employment. However, it is important for the story to be told and the findings of the study disseminated so that future practice may be improved. Thus a balance was struck between the quality of the data presented in the thesis and the protection of research participants. All service user research participants were given male identities as female service users were in a minority and could be easily identified. Also information contained in the thesis about the service and the serious incidents that occurred during the study have been kept to a minimum. Only details that were considered essential to explaining the emergence of the core category have been provided.

Obtaining consent for service users to participate in interviews caused problems with anonymity. For service users to be interviewed the multidisciplinary team needed to be consulted and their RMO needed to agree that they were capable of giving consent.

Thus members of the MDTs were aware which service users had been identified for interview. Furthermore due to safety concerns the researcher informed the nursing staff of the time and location of all interviews with service users. Thus service user involvement with the research could not be fully anonymous. To address the problem of service user anonymity data was mainly collected through observation and informal conversations with service users rather than formal interviews.

It was also difficult to ensure anonymity for ward based service providers who were formally interviewed. Ward staff needed to negotiate a time and location for their interview with shift coordinators. Interviews were often interrupted due to alarms sounding or colleagues requiring assistance and so the ward teams were aware who was being interviewed for the study. Again informal conversations were largely used to collect data. However often the ward staff were busy and so it was difficult to hold informal conversations with them. Therefore formal interviews with ward staff continued to be undertaken alongside participant observation.

4.12.4 Anonymity and publication

It is important to ensure the anonymity of the research site when the study is published. However the unique events that occurred whilst the study was undertaken may reveal the identity of the service (Van Den Hoonaard 2003). The service studied attracted a lot of negative media attention whilst the study was being undertaken. It is difficult to know what information may cause distress for the research participants if published. There is a risk that the publication of negative findings from the study might further damage the reputation of the service and service providers' relationships with the researcher, particularly if picked up by the media. The service was highly sensitised to the potential for poor publicity and at the end of the period of data collection a high ranking manager threatened to take legal action if the study was published in its entirety. However, the manager also felt that if publication was delayed until after the media furore was over and changes that had been made to the service were given time to fully embed then the study could be published.

In response to the potential risks to research participants and the concerns of the service managers, information about the service and the research participants in this thesis has been carefully used. Furthermore aspects of the research have been presented to academic audiences but as yet the findings have not been published. Thus, time has been given to the service to recover from the crises that occurred during the study.

4.12.5 Limitations to agreements of confidentiality

The assurance of confidentiality that was offered to research participants was limited. The researcher informed all research participants that she would report any information concerning plans for harm to self or others to clinicians and observations of poor practice to service managers. The researcher did not report any concerns regarding potential harm to participants. However, poor practice was observed and was discussed with research and clinical supervisors. The poor practices identified concerned nurses not following best practice guidelines or Trust policy and procedure rather than direct harm occurring to a service user. An example of a nurse not following Trust guidelines being when a nurse was observed to leave a service user unsupervised when the user had been placed under close observations by the MDT (to be in the eyesight of a nurse at all times) as they had been assessed to be a high risk of suicide or self-harm. Concerns with practice issues reflect the background of the researcher as a nurse and the tensions that she experienced in undertaking a marginal research role within a mental health care setting. Thus supervision enabled the researcher to reflect on her role and feelings of discomfort as well as the observed poor practice. It was decided that the problems with practice not following Trust policy and procedure would be included in the report provided to service managers which would highlight practice issues without naming individual service providers.

4.12.6 Consent, anticipated and emergent issues

Consent for formal interview (and focus group) appeared fairly straight forward, with verbal explanations of the study being provided for participants, together with written information sheets. The participants then signed a consent form, saying that they had agreed to take part in the study. For all stages of the study, the views of the clinical

teams and in particular the Responsible Medical Officer (RMO) was sought as to whether in their opinion individual service users were capable of giving informed consent to participate (Silverman 2000). It is debateable as to whether it is possible to have entirely free consent. In the context of the study, service users' behaviours were being assessed and so they might have found it difficult not to consent to the study (Hammersley and Atkinson 2006). The researcher attempted to address this by being sensitive to service users' behaviours and respond to any non-verbal communication that indicated that they were not entirely happy to participate in the study.

All participants were informed that they could withdraw consent to participate in any part of the study at any time. Also, if they wished they could request for any information that the researcher held about them to be destroyed. The participant would then be provided with written confirmation that data had been destroyed and that no further data relating to them would be collected. Only one participant withdrew their consent for interview data to be used in the study as they felt they could be identified from their use of language. On their request, all data collected from interactions with the participant was destroyed. However knowledge obtained from the interview provided the researcher with greater theoretical sensitivity, informing data collection and analysis.

4.12.7 Consent: participant observation

Prior to observing activities in ward areas, the researcher attended meetings with the ward staff, and service user groups. During the meetings the study was outlined, and information sheets given out. An opportunity was also given for discussion and negotiation with service users and providers regarding the practicalities of spending time on the ward. A second meeting was attended before the commencement of observations in order that any issues that had occurred to service users and providers following the previous discussion could be addressed. No concerns were raised at the meetings by service users or service providers. Service users and providers were also informed of how they might decline to participate with the study. They were told how they could let the researcher know if they wished to withdraw consent temporarily or completely, and were advised about what would happen to the material that had already been collected. Service users and providers were also given additional

reassurance about the terms of anonymity and confidentiality, and assured that the study would not affect their care or employment status. Information sheets were handed out to reinforce the information given verbally by the researcher. None of the service users or providers approached declined to be observed. However, few sheets were read by the participants and many service users were illiterate. Therefore information was largely provided verbally, and the researcher made herself available to answer any questions. Telephone and email contact details were provided on the information sheets, but no queries or comments were received by these routes.

The researcher was also able to negotiate with service users and providers about issues such as security, safety, ward routine and access to areas within the ward. Information sheets were distributed to potential participants and leaflets left in communal and office areas. Service users and providers were invited to approach the researcher outside of the meetings and discuss the study in more detail. Once the period of observation had commenced, posters were placed at the entrance to the ward and inside the clinical area to inform and remind practitioners, visitors and service users about the study.

Verbal consent was sought for participant observation to take place and for the researcher to talk informally to participants. It was decided that verbal consent would be sought as it would have been impractical to ask for written consent from all individuals in the clinical area. Furthermore the data collection was an iterative process and therefore the researcher was unable to ask for full consent at the commencement of the study (Murphy and Dingwall 2007). Also there were many visitors to the wards, including practitioners, house-keeping staff, relatives and agencies external to the Trust which made obtaining written consent impractical. Furthermore there were changes in the service users who were resident on the wards and there were several changes in the temporary or locum staff on the wards. Therefore obtaining verbal consent from the participants enabled the researcher to be responsive to changes in the ecology of the ward as well as to be flexible in relation to individual choice.

The researcher drew on the approach taken in a previous ethnographic study of a UK mental health service (Quirke et al 2004) and planned that retrospective consent would

be sought for individuals who might not be able to give consent when the observation was taking place. It was expected that users who were newly admitted to the service or who were very distressed would be unable to give informed consent. Therefore it was planned that the individual would be asked to give consent for the data to be used after it had been collected. If the user refused to do so then that particular observation would have been removed from the data set. However, retrospective consent was not used largely due to the intensive care ward being closed before observation could take place and no new admissions to the service were permitted.

4.12.8 Consent: emergent issues

It is important, to reflect on the status of the researcher as an insider or outsider, their role, power and position within the organisation when considering consent (Borbasi, Jackson and Wilkes 2003; Murphy and Dingwall 2001). Despite attempting to take the role of a researcher in the service that the researcher was assigned the role of a service provider, that was known to have a friendly relationship with many of the managers within the service. Therefore it might have been difficult for service users and ward staff to explicitly decline to participate in the study. Furthermore despite informing managers of her role as a researcher, the researcher was often asked to provide feedback on the activities of the staff, together with an appraisal of their performance. Therefore it could have proven difficult for members of the ward staff to refuse to participate as it might lead to questions to be asked by their manager about the standard of their practice. Also all the service users were detained under a section of the Mental Health Act 1983 in a secure service and it seemed that, similar to Goffman's secondary adjustment, they were keen to show willingness to conform to the requirements of the service (Goffman 1961). To some it seemed that the researcher provided new ways to show their compliance, such as agreeing for her to be present in clinical meetings. Furthermore with the assignment of categorical roles different to the researcher's own construction of the role of a researcher she found it difficult to negotiate boundaries in relationships. Often the researcher had to ask herself ethical questions such as whether a conversation with a friend was data collection, or whether she should disclose personal information to service users. Furthermore as the data collection continued and relationships were built, there was increasing concern regarding how to end relationships, and how to write a report which does not result in the participants feeling betrayed or exploited (Murphy and Dingwall 2001). The ethical

tensions that arose during the observation of the service formed part of the field notes and also memos to aid the process of analysis and further methods of data collection.

Due to the extended period of time that was spent observing activities within the service, relationships were built and consent negotiated and re-negotiated with research participants in a manner which would not readily translate to the system of ethical approval (Murphy and Dingwall 2007). Initially at the commencement of the study consent was negotiated as outlined above. Access and so consent was often silently withdrawn by senior managers, with access to meetings prevented by physical security measures. However as the process of data collection progressed the researcher became more integrated with the clinical areas within unit and participants became freer with information. The researcher was aware of the potential for research participants to overlook the purpose of the study, and reveal information that they did not think relevant but which the researcher recorded. Therefore she frequently reminded participants of her role. However, this often ended a conversation and so limited data collection. The researcher recorded information which she felt might have been given without the expectation of it being used for the study with a view to use it to sensitise herself to the research field rather than for inclusion within the study. For example conversations with service providers which occurred during down time in the hospital canteen, when service providers shared gossip and recounted humorous incidents were not included within the data set. If observations of down time produced data that the researcher wished to use she would approach the participant, ask for their consent to use the data. If the researcher was unable to approach the individuals concerned she sought the advice of her supervisors and considered the benefits and the harms of using the data to the individual and the organisation.

4.13 Summary

This chapter has discussed the following issues: the role of the researcher and her relationship to the research site; the changes to the structure of the research site and conditions within which the research was undertaken; ethical dilemmas; the methodology chosen and the methods used.

A grounded theory approach to data collection and analysis was taken. This approach enabled the research design to be modified in response to the changes that took place

within the research environment. Therefore although access to research participants became restricted, data collection could continue.

The researcher faced several ethical dilemmas which were mostly associated with events that occurred following the commencement of the period of data collection. The research was undertaken in a manner that was sensitive to the research site and the concerns raised by unit managers. Details regarding the events have been omitted from the thesis in order to keep the identity of the research site participants anonymous.

Chapter 5

Results: the reflections of the researcher

5.1 Introduction

In this chapter a reflective statement by the researcher is presented. The reflective statement provides an illustration of the researcher's background; her relationship to the research participants and familiarity with the research site.

This reflective statement provides an insight into how the researcher understood the field of research and interpreted the data collected within the present study. The researcher is a registered mental health nurse and had worked at the research site three years prior to the commencement of the study. Therefore it is important to explore her role and interaction with participants and the research site during the course of the study. The statement includes the researcher's reflections on her roles as a nurse, a lecturer and a researcher.

The background of the researcher in relation to working in forensic mental health care is outlined, followed by reflections on her social status within the field, and relationships with service user and provider research participants. The researcher then reflects on her strategies that she used to manage the role tensions that she experienced whilst in the field.

5.2 Background to working in forensic mental health care

I developed an interest in forensic mental health care following short placements in a medium secure service, and attending lectures about forensic mental health care whilst I was a student nurse. After qualifying as a mental health nurse I worked in an acute adult ward for a year before moving to work in secure mental health services. I worked at a low and medium secure forensic service from 1998 until 2002, when I left to work as a lecturer in a school of nursing. In 2005 I successfully applied to the Health Care Foundation for three years full time funding as a doctoral research fellow. I chose to undertake an observational study of forensic mental health services. I was particularly interested in the dissonance between formal risk rhetoric and the day to day practice on the ward upon which I worked. I was also interested in the relationship between

forensic service users and providers, and how they negotiated the implementation of security measures within an apparently rational and formal system.

I commenced work in 1998 as a charge nurse on a fairly quiet rehabilitation / pre-discharge ward which was part of the medium secure service. The ward had been nicknamed sleepy hollow by members of staff working in other parts of the service as the ward was so quiet and was physically separated from the main medium secure service. I then undertook a 6 month secondment to the peripatetic forensic community team. The peripatetic team offered support to rural mental health services that did not have expertise in forensic mental health care. On return to the in-patient service the manager of the ward where I had been previously based sent me to work on the acute admissions and intensive care ward. The intensive care ward was renowned for being an unfriendly and pressured ward, and I understood the move to be a punishment for leaving the rehabilitation team to work in the community. I only worked for a short time on the intensive care ward as within four months I had joined a team that had been newly formed to open the minimum secure forensic service. After a year working on the low secure service as a charge nurse the ward manager left and I was asked to act up into the role of ward manager. After approximately 4 months I was appointed to the substantive role of ward manager. I left the service in 2002 and commenced data collection in 2006.

I chose to return to the unit to undertake the present study as I had maintained good relationships with service providers which I hoped would enable me to gain managerial approval to undertake the study within the service. I had worked in forensic services for several years and given the high profile of many service users and the need to maintain security I felt that it would be difficult to gain access to a secure unit to undertake participant observation without having any established relationships or good will.

I had also enjoyed working at the unit and felt that service users and providers would be open to being involved with the study. However, alongside enabling access to the research site, familiarity with the service also brought some difficulties with maintaining

theoretical sensitivity and maintaining the perspective of an outsider. (This is discussed in more detail in section 4.9).

During my employment within the forensic service I had developed professional and social relationships with staff and service users. Many of the relationships with staff had been maintained through providing advice and attending social events after leaving the service. However, inevitably during the three years that I had left the service I lost contact with many people and eventually I only maintained one professional relationship. Thus although at the commencement of the study I was not a stranger to the field, I had developed some distance and unfamiliarity with the service. However I found that I still needed to work at making the familiar strange.

One example is that, perhaps because I felt I knew the unit, I did not research its recent history prior to obtaining access and commencing the data collection. Therefore I was not prepared for the degree or extent of the impact on the service of a homicide inquiry report which was published shortly after the commencement of the study.

5.2 Entering the field of study

I entered the field with some trepidation as I was unsure as to what my status and positioning within the service would be. I was also worried whether with a new and different power dynamic, staff I had previously managed would welcome me, or use the opportunity to take out any bad feelings against me. Therefore I was surprised but pleased when upon entering the service I was greeted by several unqualified members of staff who referred to me as the 'boss', and hugged me. One member of staff who was unknown to me approached me whilst I was in the hospital grounds and gave me a hug. She said that she had been told about me by her colleagues who had previously worked with me. The main gatekeepers for the project, who were both ward managers within the service had worked with me as charge nurses both when I was a charge nurse and then their ward manager. Previous relationships therefore aided access to the field, and enabled me to enter an otherwise closed community. However, the relationship between me and the gatekeepers could be problematic. The gatekeepers and other members of staff conveyed status upon me due to my previous roles and

current employment as a lecturer in a University or 'ivory tower'. Often the managers would introduce me to members of staff as their previous manager, or as the ex-manager of the low secure ward. These introductions made me feel very uncomfortable and exposed as a senior nurse rather than purely being a researcher. Also I had to ensure that I didn't inadvertently usurp the power of the ward managers by allowing the ward to staff to call me 'boss' and ask my opinion about what was happening on the ward / clinical care.

5.3 Social position in relation to research participants

I found myself to be quite uncomfortable with openly being given a high status label as a manager and lecturer, rather than a researcher. I felt that I had been exposed as being more than a researcher, that my cover had been blown, and that perhaps individuals were being warned of my past affiliations. I became concerned that ward staff and service users would be suspicious of me, and less likely to trust that the information I gathered would be kept confidential, as I had been aligned with the senior managers. Also I felt that service users and providers would change their behaviour around me, to ensure that they presented as good nurses or good patients.

My reaction to the field helped me to be more aware of my ontological and epistemological assumptions regarding reality and to be able to reflect upon my thoughts and feelings within a symbolic interactionist framework. I was acutely aware that I was not a neutral observer, but an active member of the community and as such was involved in the situations that I observed and recorded. One example of my involvement was being asked by ward staff for advice and support. This placed me back into the role of a leader within the service leader which I found flattering, although at the same time I was aware that by engaging with staff requests for support I was potentially undermining managers within the service and jeopardising their continued permission for access to the research site.

However, despite my concerns for my impact on the field and attempts to withdraw in order to capture a 'reality' that my presence seemed to be changing, I was quite seduced by my seemingly senior status and quietly enjoyed the reaction of the nursing team. One example is when of the charge nurses who later became an acting ward manager remembered that I had interviewed and appointed him as a charge nurse

some years ago. He has since asked me for advice regarding his application for the ward manager post and to be his 'mentor'. Other nurses applying for the same job also asked me for my help with the application process. Therefore there was quite a narcissistic element to my interaction with the field. I needed to be aware of the dangers of adopting a senior nursing role within the service as it could alienate me from gatekeepers and other managers and clinicians within the service, who might view me as undermining their role. Also members of the nursing teams could be seen to be splitting between me and their managers, with the manager who had told them something negative being seen as all bad, and myself as the good manager and leader. Therefore I found that I needed to keep reflecting on my behaviour whilst in the field and attempt to avoid providing advice or guidance unless asked to do so by the managers. However this was a fine line to balance with maintaining (clinical) credibility with the nurses and the senior clinicians, who might ask for my opinion on an issue. For example a consultant psychiatrist who I had known previously asked me to "sort out your colleagues" when the nurse in the ward did not have their report ready when it was needed.

5.4 Relationships with service providers

I was included in the social groups of managers and senior clinicians with whom I had worked previously. Often I was trusted to be party to gossip and story telling regarding situations or incidents that individuals had been involved in within the service. Stories were told that were short and humorous others that raised individual status or were high profile were repeated. Comical stories often used black humour, and provided some light relief to situations that would otherwise have been quite stressful or upsetting. Other stories placed individuals in positions within the social structure.

However, boundaries often became blurred due to existing social relationships and friendships with service providers. It was difficult to ascertain when a conversation was on or off the record; did gossip during lunch constitute data, what were the ethical implications? I was unsure if I was betraying a friendship or collecting data as a researcher. I couldn't constantly remind individuals that I was collecting data, however on occasion I would reassure individuals that I wouldn't include information that they had told me. Also I would use my discretion not record information gathered from

informal discussions outside of the workplace. Instead I would use the information that I had been given to sensitise me to the field. However despite these precautions as the time for the research to be completed and the report to be written, many individuals that I had social relationships with seemed to become suspicious and avoid discussing sensitive subjects in front of me. Therefore the social group of which I had become a member maintained its boundaries through peer pressure and unspoken agreements. I chose to self censor, and not record or report discussions that took place, even when there was no specific agreement to omit discussions from the data. I was not aware of what I was doing at the time, however I was keen to be an insider, and membership of the group appeared to be dependent on adherence to unwritten rules. Thus I bowed to peer group pressure and regulated my communication, suppressing information that might be harmful for the members of the social group in order to maintain group membership.

The peer pressure to regulate my communication that I encountered may in part be explained by an event that had occurred within the service, of which at the time of data collection described above I was not aware. A complaint had been made against the managers of the service, which was being investigated. At the time of the completion of the data collection I was made aware that an anonymous complaint regarding managerial nepotism and racism within the forensic service had been made, and an internal inquiry into the allegations had begun. Therefore it might be unsurprising that managers within time service had become suspicious and defensive. How I interacted with the field and the impact on my role of participant observer is discussed in more detail in the methodology chapter.

I discovered that I was an anomaly within the service as there was no researcher role in the structure. Therefore participants were suspicious of my role. I found that soon after I commenced data collection I began to be aligned with the nursing or managerial staff by the participants. Thus I was fitted into the organisational structure. I was wary of being identified as being part of the nursing team as I felt that the service users would not engage with me. However, on the contrary I found that once I had been aligned with a recognised group that the service users were more willing to talk to me. I remained separate from the nursing team in some ways as I did not have the free access to the unit or authority of an employee of the service. Thus I felt that I had adopted a marginal position in the nursing team. However this differed between wards,

with one ward allowing me to have the ward keys, to manage the ward whilst there was a team meeting and to let others in and out of the ward. On other wards I was not allowed a set of keys and even had to ask a member of staff to let me into the toilet. Occasionally on the ward where I was not allowed keys staff would forget I was not an employee and hand me their keys to use, only later rushing up to me to retrieve their keys when they had realised what they had done. This marginal status whilst enabling me to have a recognisable identity within the service, led participants to question my role and me to question my identity, as a nurse, a researcher and an individual. In being in an anomalous position within the service I felt that I had to re-define my identity both for myself and for the participants. Thus I attempted to assert my role as a researcher. However, invariably I would conform to the roles assigned to me by service providers and users.

The changes made within the organisation following the publication of the homicide report affected my relationship with the service, particularly with the managers of the service. The physical and procedural changes to security affected my ease of access to the unit. In many ways this altered my positioning within the organisation, flagging my status as an outsider. Furthermore once the changes in security began to take place meetings that I had been able to attend as a privileged previous employee became closed to me. The senior management team excluded me from meetings initially planning meetings, business meetings and eventually advocacy meetings, despite being invited to attend by both service users and the advocate. On one occasion I was invited to attend the clinic advocacy meeting by the advocate, patients from the ward on which I was working and the ward manager. However a secretary met me at the door of the meeting room and attempted to prevent me from attending and I was only able to attend the meeting with the insistence of the ward manager and patient representative.

As a registered nurse as well as a researcher and I remain accountable to the Nursing and Midwifery Council (NMC). I knew that it would difficult to witness poor practice whilst collecting observational data without intervening. Therefore I anticipated that I might experience some difficulty in resolving my roles of researcher and nurse. In response to this potential role conflict I made it clear in the information sheets that although I would maintain the anonymity and confidentiality of participants, I would report behaviour that was harmful to service users or staff. However, it was problematic

to define the point at which poor practice became harmful, and what degree of harm would warrant reporting an individual's behaviour to the senior management. Often during my attempts to tolerate the poor practice during periods of observation I would realise that my discomfort was noticed by individuals within the field. I was conscious that my reaction to poor practice might be interpreted as a criticism by research participants. I was not intentionally intervening in incidents or involving myself in clinical practice that inadvertently. However, I was communicating my approval or disapproval of nursing staff actions and affecting individuals' behaviour.

5.5 Relationship with service users

During periods of observation I spent a considerable amount of time interacting with the service users on the wards. I had known some of the service users in my previous role as a nurse working within the service and generally had a good relationship with them. Established relationships helped with developing alliances with other service users within the ward who had previously been unknown to me. Existing relationships also gave me some status as it was known that I had previously been a ward manager on another ward and was not an unknown researcher. I formed friendly relationships with many of the service users. Different to my previous role within the service I was able to relax and enjoy talking freely to the service users without having an underlying agenda of treatment, assessment or reporting back to the ward round and recording information in the notes. The power balance in the research situation felt very different to when I worked as a nurse. I felt I brought the outside into the ward, and when visiting to undertake observations I felt that I had to bring news, information about the community, something to help the service users pass the time. Often it was the service users that welcomed me onto the ward with offers of tea or a seat in the circle of discussion. However I always felt slightly uncomfortable in relation to where the boundaries lay. The boundaries had been very clear when I had worked previously as a manager within the service, however now that I was not employed by the NHS what kind of relationship should I now have with service users? I felt torn between my identities as a nurse and a researcher. As a researcher surely it would be wrong to expect the service users to be open and talk to me about their views and experiences of the service / life without me sharing mine. If I wasn't prepared to share something of myself then how did that reflect my views of service user involvement and service user led research and care? However the service providers seemed to view me as still being

a nurse and as such trusted me not to cross boundaries. I felt that if I become too friendly with service users that problems might arise with my credibility with the nursing team and so might affect my continued access to the service. These areas were also more marked when there had been an incident on the ward and service users were tense – I then became an outsider.

5.6 Ethnicity and relationship with research participants

As a white, middle class woman who had previously worked as a manager in the forensic service, I could not easily be aligned with a predominantly black, African nursing team. I was very much welcomed by the nurses on the ward but felt that I was somehow other due to my background and ethnicity. The ethnic divisions within the service provider team were highlighted when I was approached by white English nurses who wished to speak with me about how they had been excluded from the nursing team. I felt uncomfortable with conversations that were initiated by white nurses about black nurses. I questioned whether conversations about the black nursing team at times became racist. However I empathised with the white nurses' feelings of marginalisation. I was concerned that I was being invited to align with white nurses which might affect my relationships with black service provider participants. As the study progressed I discovered that the divisions existed within the nursing teams along lines of ethnicity and language rather than colour. Nurses from the Caribbean approached me to talk about the problems that they had encountered when working with African nurses. African nurses spoke to me about problems they were having working with nurses who were from a different African country to themselves. Thus I became aware of the existence of a complex system of social groups that had formed along ethnic lines within the service provider teams.

5.7 How the researcher managed tensions within her role of participant observer

The tensions that I experienced whilst in the field varied according to, changes in conditions at the research site, and the location and type of my data collection activities. Furthermore tensions between my roles of researcher and confidante became more acute as the study progressed and relationships were built with research participants. I addressed many of the tensions that I experienced through keeping

Careful notes of the situation and recording my reflections both when I was in the field and outside of the field. I also took issues that I found difficult to address to clinical and research supervision. One issue that I took to my clinical supervisor was how I was relating to the charge nurses on the ward, and attempting to make more explicit the boundaries between my role as a nurse and as a researcher. I also utilised research supervision to discuss issues of safety within the clinical area and to maintain some distance to the field as well as sensitivity (see chapter 4 for a fuller discussion).

5.8 Summary

The reflective statement outlines the researcher's relationship with service user and provider research participants, and the tensions that she experienced in relation to her roles as researcher, nurse and former colleague. The researcher's reflections on her roles and her interactions with service users and providers in the field provide an understanding of the difficulties and dilemmas she faced during data collection as well as her interpretations of the data.

In the next chapter the data relating to service user participants' regulation of communication in an attempt to manage their risk status is explored.

Chapter 6

Results: The regulation of communication by service users

6.1 Introduction

In this chapter the regulation of communication by service users in an attempt to manage their risk status during their inpatient stay will be discussed from service user and service provider perspectives. The data presented will be used to illustrate how service users modify their behaviour and silence their dissent in response to the organisational ecology. Data will also be used to explore the service provider response to and perceptions of the regulation of communication, in particular as part of the organisational process of risk assessment.

It is argued that service users manage their own risk status through the regulation of communication, for example by silencing their negative reactions to violations of cultural norms. Service users seek to manage their risk status in order to hasten their clinical progress and so promote their progress towards discharge. Service users perceive that negative reactions might be viewed as risk indicators by the multi-disciplinary team, which could slow progress towards discharge. The violation of cultural norms occurs as an inherent part of the detention and assessment of individuals within the medium secure unit. In particular due to the need for surveillance within secure services the privacy of the service user must be compromised on the grounds of safety. Service users described striving to embody and maintain characteristics of compliance through silencing dissent and behaviour that might indicate resistance and thus be construed by clinicians as indicators of risk.

The activities that regulate communication will be explored and will include the self-censorship of voice, accepting inactivity and 'doing time'. Performing compliance is distinguished from silencing as an active way for service users to manage their risk status. The regulation of communication by service users to meet the perceived demands of the organisation and so progress towards discharge is discussed in the context of a service user research participant's description of it as playing a game with

service providers. The game is played between the service user and the service provider, with the service user attempting to portray a compliant self, and the service provider attempting to expose any deception and thus identify potential risk. Game playing was not without risk and problems experienced with the regulation of communication and assessment will also be explored. Difficulties included maintaining a sense of self, and needing to contain and manage unresolved problems.

The problems of service users' having their voice heard within the organisation will firstly be explored, followed by the regulation of communication as the playing of a silencing game by service users and providers. Problems with playing the game will firstly be explored from the service user perspective and then from that of the service provider.

6.2 Problems with service users being heard by the organisation

This section outlines and discusses the difficulties that service users experienced in having their voice heard within the organisation. Limitations of systems put in place within the organisation to enable service users to voice their concerns will be also explored. Thus the context and an indication of motivations for game playing by service users will be provided.

Ray, a service user described how he believed that not being heard was an inherent part of hospitalisation. He described how he felt that didn't have a voice regarding ward issues as he was either not heard, or was silenced by service providers.

What I wanted to say was it is difficult in here sometimes because you haven't got a voice. You know you want to say certain, like in community meetings when we disagree with something like the smoking for instance, we want to say to [ward manager], can we smoke, have different smoke, er have extended smoking time and he says no. And we say, we, we, we can't voice our opinions. If he says no that's the end of it. We can't argue that, he won't deviate from that you know. We've got a voice but it stops at [ward manager]. If he says no it stops there and

that's the end of it and I don't think that's right, you know, we should be heard. That's not just smoking, that's like a trivial little thing but other things that have happened. Before you have arguments with the staff or something like that. They, they are right and we are wrong. Even if we are right they don't hear that. We are in a mental institution and we're, you know, it's not, we are not heard.
(Ray, service user: interview)

Ray described the limitations of service user voice. Service user opinions were filtered by the ward manager. If the manager decided that the service user views were unacceptable or invalid then they stopped there. Furthermore, from Ray's perspective, in disputes between service users and staff, the service users would always be found to be at fault. Ray depicts himself as continually attempting to be heard, and highlights the corresponding institutional prompts for him to silence his voice. Thus according to Ray's account it would appear that service users were socialised into regulating their communication by the responses of the staff team. The ward community meeting was for service users to raise issues regarding the ward environment and rules. However Ray identified that there were some ward rules such as those regarding smoking that cannot be challenged at the meeting. Thus, Ray had learnt from the response to previous complaints he has made what would or would not be listened to by service providers. He attributes the loss of voice to being in hospital. His voice was not lost because he was a mental health service user, but because of his present in-patient status. Furthermore he did not refer to being a forensic mental health service user, and so does not link his loss of voice with his forensic status. However, all individuals who were resident in the forensic mental health service were detained under the Mental Health Act. They have less autonomy than users of other mental health services, who may not be detained and were subject to care that was more routine and controlled than other services. Ray felt powerless to challenge the nursing staff, but he was resigned to not being heard. The loss of voice was part of the process of institutionalisation, he was powerless to change the system and so he must tolerate it.

Difficulties with service users' views not being heard by health care providers were recognised by the previous New Labour Government. The amendments to the Mental Health Act in 2007 placed a duty on NHS Trusts to provide independent advocacy services from 2009. Patient Advice and Liaison services (PALS) have since been established across NHS services. The role of the PALS service is to help service users

to access information, help them to resolve problems and support them through the complaints procedures. Regular reports are provided by the PALS service (NHS 2010). However it is unclear as to the extent to which service user voices are actually heard and acted upon. The advocacy service at the research site was based within the hospital and sought to give service users a voice, so that they could influence their environment and the care that they received. During an interview, Sandra an advocate outlined the role of the advocacy service as she saw it.

the emphasis is in recovery and also on enabling the patients to have a voice, and have a say and to be able to find out information with the help of the Advocate regarding conditions they find themselves in on the unit.
(Sandra, advocate: interview)

Sandra's description of the role of the service indicated a belief that, with the support of the advocacy service, service users' voice would be heard. Service users not only lost their voice whilst an inpatient, but were also not given information regarding their detention. Thus, service users were in a very vulnerable position whilst resident within the hospital. Sandra identified forensic service users as being particularly vulnerable as they were not invited into MDT meetings and so were not directly involved in decision making regarding their care.

I think on forensic wards its almost like advocacy has more of a role in terms of getting the patients voice heard. Because quite a lot of the consultants who work on the forensic ward have a policy of not necessarily inviting their clients into their weekly ward rounds. So that clients don't have a lot opportunity to interface directly with the people who are making decisions about their treatment and care.

(Sandra advocate: interview)

Sandra differentiated between the needs of forensic mental health service users and the users of generic mental health services. Thus unlike Ray, Sandra framed the service user and the service according to their forensic status. It was Sandra's view

that as forensic mental health service users were not invited into ward rounds, they could not directly influence individuals that were making decisions regarding their care. The observation of ward rounds revealed that service users were only asked to come into the meeting once a discussion had taken place and a decision had been made by the team, as demonstrated by Jason's situation which is discussed below. Service users were invited into the meeting and then informed of the decision that had been made. Often service users chose not to attend the ward rounds, absenting themselves by either directly refusing to attend or remaining in bed for the duration of the meeting. It is unclear why service users did not attend. Often reasons given were that they were engaging in another activity, or did not have any requests. For service users to have their requests discussed by the ward round they needed to attend and make the request to the clinical team directly. Thus service users often disengaged with the decision making process and did not discuss the decisions made regarding their care with the team, seemingly taking a fatalistic approach.

Non-attendance at ward rounds could also be used as a means of resistance. During the observation of a ward round a nurse was sent to ask a service user to attend the ward round. However the nurse returned alone

Doctor: *is [patient name] coming?*

Nurse: *he wants to wait for a new consultant*

Doctor: *I am just a lame duck consultant!*

The service user had requested a change of consultant and refused to engage with their existing consultant until they were re-allocated. Through refusing to attend the ward round he was strongly asserting his wish to have his consultant reallocated. Thus by disengaging with decision making rather than losing their voice, the service user was able to make their views known.

During the period of data collection by observation changes began to be made to the way in which ward rounds operated. One of the wards in the service pioneered a

format in which service users were invited into the meeting for the entire period that they were discussed. During the planning process for the change of format the consultant psychiatrist raised some concerns regarding holding discussions in the presence of the service user.

Lets not make a snap decision here, in principle I agree like CPA [Care Programme Approach meeting] but there are things we don't want to say in front of them, we could risk damaging the relationship.

(Phillip, consultant psychiatrist: observation)

The format of the ward round was to change to that of the CPA (Care Programme Approach meetings). In contrast to the weekly ward rounds, the CPA meetings were held infrequently and involved an in-depth discussion of the care of one service user. The service user was present throughout the majority of the meeting, and could bring in relatives or legal representatives. Phillip expressed concerns that if the service user heard the whole discussion at the MDT, then the relationship with staff might be damaged. By implication the relationship that the MDT has with the service user is not an entirely honest one. From this consultant's perspective, at least some personal and professional views which the service user might disagree with needed to be hidden from them, even in the new open format of the meeting.

Adam, a psychologist, also raised concerns with the team that by inviting service users into the whole MDT meeting the lack of a scientific process would be revealed. Thus the relationship might be damaged as the belief in a scientific system of assessment and decision making might be eroded.

It is not always transparent, not always a rational decision making process...very off the hoof these decisions. (Adam, psychologist: observation)

Thus it remained difficult for the service user to influence decision making even though they were invited into ward rounds. Service users were unaware of all the variables that

were being taken into account, as possibly were the MDT. In order to influence the MDT, service users must be able to ascertain clinicians' views and working frameworks beyond the information that they were given directly by the team at the ward round. Possibly due to these difficulties some service users chose not to attend their ward round. One example was provided during the observation of a ward round which service users refused to attend as the meeting clashed with their smoking break.

A nurse who had left the ward round room to collect the service user who was to be discussed returned to the meeting alone.

Nurse: *no, [service user name] is not coming until after smoking time.*

Doctor: *I think this is a bit of sabotage*

Ward manager: *I will discuss this at the community meeting!*

The doctor was frustrated with the situation and interpreted the service user refusing to attend the meeting as a deliberate attempt to sabotage the changes that they had recently made to the format of the ward round. The frequency and the duration of smoking breaks for service users was a bone of contention between service users and ward staff. The service users complained that they had insufficient time to smoke; the ward staff felt that they could not find time to supervise additional breaks. The non-attendance of the service user at the ward round could be interpreted as the service user making their point regarding the need to increase smoking time. They were also valuing smoking above engaging in the MDT discussion about their care. Thus it would seem that the service user chose not to have a voice in the MDT meeting in order to assert their views about the ward smoking rules. The doctor's comments that the service user was sabotaging the ward round suggested that the ward round remained the domain of the MDT, rather than a shared decision making forum for service users as well as providers.

Anonymity was another difficulty associated with enabling service users' voices to be heard, which was highlighted by Janet, an advocate. She described how service users

were worried that they would be punished for making a complaint. In consequence, advocates would try to keep the service user's identity a secret and make complaints on their behalf. Staff also described voicing concerns or dissent anonymously. This is discussed in section 7.3.

some patients might not want us to tell the ward manager, they fear they might be penalised for having raised issues. So some of them will want to raise their issue anonymously....we will offer to represent them without disclosing their name, if necessary. Its difficult though because ...if it's a complaint then the person receiving the complaint wants to know, wants to hold their own type of investigation into the issue. And if we won't disclose the name then it becomes problematic for them in order to investigate it themselves. But on the other hand you know the other thing that we might do [informally talk to the manager] in those circumstances if somebody feels particularly vulnerable to being picked off

(Janet, advocate: interview)

As with many of the ward staff, the advocate seemed to construct the service as being a negative force. However Janet described that for service users the ward staff formed part of the threat, with service users who make a complaint potentially being *picked off*. The forensic service users reside within a locked, secure service and so spend the majority of their time with ward staff. Service users might also stay within the service for many years. Therefore, the relationship that users had with staff greatly impacted upon their quality of life for a significant period of time. However, if the advocate did not disclose the source of the complaint, it would be difficult for the service to investigate any allegations made. The forensic mental health services had little scope to address unsubstantiated complaints, and so the power of the advocacy service is limited by their need to protect the complainant from the fear of retribution. Thus it would seem that fear prevented the advocate from giving service users a voice. However it is unclear whether the systems in place for service user voice to be heard were ineffective, or deliberately silencing.

Communication by the advocacy service was regulated by the forensic service. Janet described how the advocacy service needed to follow organisational procedures in order for service users' voices to be heard.

We've just found through trial and error that actually it doesn't help, basically to, not to go through the procedures. It leads to a better outcome in the end ... I would say through experience we've achieved more and we have got into hot water through raising things in public meeting. There has been an occasion where one of the advocates raised something in a public meeting, which was an issue, which was sort of being dealt with by the service manager at the time. And yeah, it didn't cut any ice.

(Janet, advocate: interview)

In order to be effective at representing the service users the advocacy service needed to ensure that procedures were followed. Janet defended the use of proper channels, believing that the advocacy service was more effective when it followed Trust procedures. Thus Janet perceived that decisions were made regarding complaints according to the level of conformity to policy and procedure as well as the evidence provided. Janet provided one example of an advocate who got into trouble with the service managers for not following procedures and raising an issue in public. Thus service managers contained complaints within the organisation by channelling them through Trust systems and thereby protecting the organisation's reputation.

Therefore it appeared that service user complaints challenged the organisation, and organisational procedures put in place to promote service user voice serve to regulate and contain communication. Systems to enable the service user voice to be heard had been put in place such as community meetings and advocacy. However, communication was also regulated within these systems. Service users' fears of retribution were identified by the advocate as a strong factor in their regulation of communication. However, there is no evidence that staff took retribution against service users for complaints they had made. Thus, the fear of retribution could be interpreted as an indication of service users' perception of their powerless position within the organisation. As illustrated in section 6.3 service users such as Sam chose

not to use recognised systems such as advocacy to deal with his frustrations, but instead silenced complaint, and played the game.

6.3 Playing the silencing game

The data presented will be used to construct silencing by service users as a demonstration of their compliance to organisational rules and routines. Non-expression of dissent will be interpreted as a means by which service users attempts to modify service providers' perceptions of them as risk objects. Non-expression was mostly self-reported by service user research participants. However non-expression was also indicated by reports by research participants of an absence of an expected response by others. An example of the absence of an expected response is given below. During an MDT meeting, Judy an OT, questions a nursing report of a service user not expressing frustration over the past week.

No signs of anger and frustration, but she must be frustrated by what happened in the MHRT (Mental Health Review Tribunal).

(Judy, occupational therapist: observation)

It is unclear whether Judy was questioning the accuracy of the nursing report or the behaviour of the service user. However Judy drew attention to the absence of expected expression, thus indicating her own expectations. However, using individuals' expectation of another person's response is problematic as expectations may differ according to the individual and the context. Furthermore it is unclear where an individual's expectations come from. Therefore research participants' self-reports of withholding communication with service providers were largely relied upon as evidence of silencing.

The data presented below were obtained from an informal interview during participant observation. I engaged a service user (Martin) in a conversation regarding the decisions made during a ward community meeting at which we had both been present. During the meeting the researcher had observed that Martin had remained silent and

not supported a group of his fellow service users who had complained about ward rules. However, in a conversation we had had prior to the meeting he had expressed his dissatisfaction with the rules. When the researcher asked him why he had been quiet during the discussion he explained that he believed that he needed to demonstrate compliance in order to progress towards discharge.

There are vulnerable people in here and they are taking advantage of that. I have said too much already. People on the ward may find out. I thought about making a complaint about these petty rules but it will come back and hinder my progress ... Anyway I am not here forever, I will just need to play the game and wait ... You need to train yourself, get used to just sitting.

(Martin, service user: observation)

Martin perceived that to openly challenge ward rules that he disagreed with would negatively affect his assessment. He responds to difficulties he experiences with the ward regime by *playing the game*. The *they* that Martin referred to were the ward staff, who were *taking advantage of vulnerable people* by getting them to conform to ward rules and making their work easier. Martin commented that he had said too much already. Therefore it would seem that, although Martin did not view the researcher as *one of them*, he also aligned the researcher with the staff and by implication did not entirely trust her not to report back to the nursing team what he had said. The people on the ward that he feared might find out about his views also included his fellow service users. Ward staff had expressed concern in handover meetings that service users who wanted to change the ward rules were bullying other service users into attending the ward community meeting and voting in their favour.

The game that Martin described was of containing or displacing his dissent and portraying satisfaction with his care, in order to meet the perceived organisational risk assessment criteria, and so improve his prospects of discharge. Martin had adapted his speech and behaviour according to his perception of organisational risk assessment processes. Thus it would appear that the doctrines of psychiatry that Goffman described as dictating the re-socialisation process within mental hospitals and prompt service users to the play the social game where the patient works to get well have been

overlaid and justified by risk (Goffman 1961). The social game has undergone a metamorphosis into one of managing risk status by behaving in a socially acceptable manner. Martin's description of his actions as playing the game suggested that there may be a set of rules one must learn in order to play the game effectively. For Martin the game was observed to involve sitting in communal ward areas, quietly doing time and remaining visible, and yet not doing anything noticeable. Prime facie these actions do not seem to require skill or effort. However, as discussed below, the researcher found that sitting and waiting required skill and endurance.

However, during participant observation the researcher engaged in Martin's silencing activities and found that sitting and waiting quietly was difficult to achieve, and as Martin mentions requires some getting used to. Often, whilst sitting quietly with service users for long periods of time, the researcher would become restless and bored and would move position, often changing seats to get a different view of the ward, a behaviour which could be interpreted by others as an indication of agitation. Alternatively the researcher would find sitting soporific and begin to feel drowsy, which could be pathologised as lethargy. Thus within the context of a mental health ward the behaviours of a service user could be understood in terms of his diagnosis and used as an indication of mental ill health (Rosenhan 1973). Like many service users the researcher preferred to sit where she could see the door to the ward. This enabled her to pass the time by watching people coming in and going out of the ward, and possibly engage in conversation and get news from outside of the ward. However, when the researcher was sitting with the service users, members of the multidisciplinary team whom I knew, and who had recently spoken to when observing the nursing staff would often walk past without saying hello or engaging in conversation, with her or the service users. The researcher was annoyed that the clinicians didn't greet her or Martin when they walked past. Initially the researcher felt that the clinicians were being rude. She was also bored and looked forward to someone new coming into the ward, someone who might provide an opportunity to engage in a fresh conversation. However, the clinicians coming into the ward walked past without acknowledging her. Later the researcher began to feel invisible, that perhaps she no longer mattered to the clinical team. During a period of observation the researcher had an informal conversation, with a service user who was sat near the ward door. He echoed my thoughts regarding sitting and waiting.

It makes me feel good when people say hello to me, it makes my day. There are some days when nobody says hello. [falls silent]

(Richard, service user: observation)

Sitting and waiting seemed to erode one's self-esteem, and evoke feelings of worthlessness and abandonment.

In response to the researcher's experiences Martin acknowledged that sitting quietly in order to play the game was difficult and required skill, that it was something that you needed to train yourself to do, to get used to. Skills of endurance and the toleration of inactivity were of particular importance when waiting, as to be observed by staff being restless or drowsy might be taken as an indication of mental state. Thus for Martin the game had strong temporal and containing aspects. Martin felt that he must wait patiently and hold fast any emotion or behaviour that might draw negative attention from service providers. The researcher's participant observation of Martin showed him seeming to fade into the background of the ward, present but not noticeable.

Martin took a fatalistic approach to playing the game, as he could not change the system. However he attempted to manage his risk status by playing the game and waiting quietly until service providers decided that he was ready to be returned to the community. He was doing his time, as if imprisoned, but without a known date of release to aim for. He believed that logically his detention must at some point come to an end. Thus, Martin's game was primarily one of waiting and hoping. Martin's waiting was observed to take place in the communal areas of the ward with him hanging on patiently for something to happen, not complaining about delays or problems and interacting politely but minimally and superficially with nursing staff. Martin would quietly sit on his own waiting for activities or smoking breaks to take place. Sitting in the communal areas enabled Martin to be observed by the staff as being patient and quiet. By just sitting Martin ensured he was visible, available to be assessed whilst not attracting any unwanted attention from the nursing staff. Thus Martin appeared to be using inactivity to gain the approval of staff and so indicate his readiness for discharge.

Another service user (Justin) also described behaving in a way which he felt would not provide the service providers with justification for his continued detention. During a period of participant observation Justin was sat on a chair in the main corridor of the ward, outside the meeting room. He was observed to be anxious; he was waiting to be called into the ward round. Justin described being worried about going to the ward round and talking with the multidisciplinary team (MDT). He feared being told he had done something wrong, and the MDT delaying his discharge.

It's like being at school, going to see your teachers [ward round] I just try not to do anything wrong, so they don't have an excuse to keep me here.

(Justin, service user: observation)

The metaphor that Justin used of being at school indicated that he saw himself as being in a relatively powerless role, that of a child. He described the MDT as the teachers, as people who would assess him, reinforce the institutional rules and would interact with him didactically. From Martin's description his experience of the forensic service was an infantilising one. As a child Martin must learn his lessons from the MDT and so develop, mature and re-gain adult status ready for discharge back to the community.

As with Martin, Justin was actively doing his time, attempting to meet perceived organisational demand characteristics whilst waiting to be discharged. However for Justin it was a precarious path towards discharge, one where his actions might unexpectedly result in continued detention. Therefore he perceived that the MDT were actively attempting to keep him in hospital rather than working with him towards being ready for discharge. Justin seemed to be describing the clinicians attempting to detect any behaviour that he might inadvertently display which did not conform to the organisational rules. However Justin did not seem to intend to deceive the MDT, rather he believed that he was doing what was expected of him. He had learnt from the responses of the MDT that he must not do anything wrong. However, it appeared that Justin was unclear about what was regarded by the MDT as being wrong. He must learn what is wrong experientially, through the ward round feedback. Justin must anxiously wait, to find out how his behaviour was assessed over the past week by the

MDT, and how it would affect his progress towards discharge. Thus the MDT is described by Justin as a punitive authority which must be appeased through displays of conformity to unarticulated rules in order to be released.

Another service user, Carl who had been detained in the service for a lengthy period of time described how he played the game. During a period of participant observation, the researcher noticed that Carl spent the majority of his time in the main ward areas. However, he often appeared quite sullen, and complained about spending time in the communal ward areas where he would have to interact with service users that were more unwell than him. Thus, Carl seemed to be commenting negatively on his own compliance by appearing dour. There was no evidence that this had been picked up by the ward staff. However Carl was a long term patient whose demeanour was accepted by staff as part of Carl's character.

The researcher therefore asked Carl why he spent so much time in the communal areas when he clearly disliked being there. Carl explained that he spent time in the main ward areas because he felt that not doing so would be interpreted negatively by staff. In this way Carl mapped out the areas of known surveillance by ward staff. The comment was made only to the researcher. However the comment was made in an open area which gave the impression that Carl did not mind if the ward staff heard his comment.

I'm sitting here interacting. If I sit in my room I am either isolating myself or antisocial!

(Carl, service user: observation)

Carl was quite irritable when giving his response and it seemed clear that he felt he had no choice other than to spend time in the main ward areas. He expressed a belief that if he were to spend time alone in his room his behaviour would be pathologised by the ward staff, understood in terms of his diagnosis, and thus seen as an indicator of risk.

The main ward areas were subject to the most surveillance by ward staff. Carl attempted to display sociability whilst present in the main ward areas in order that he may be observed by ward staff. Carl wished to be observed by the ward nursing team to be acting as a compliant and sociable service user. However, with other service users he distanced himself from this role through voicing his frustrations with his situation. Nursing observations of service users' behaviours are reported to the MDT at the weekly ward round meeting to inform clinical decision making. It appeared that Carl believed that if he was reported to be conforming to perceived service requirements then he would be allowed a greater level of freedom. Carl modified and censored his voice rather than silenced it. He continued to speak to peers and staff but did not voice his concerns. Carl identified a need to interact and be sociable whilst employing the strategy of sitting and waiting in the communal ward areas. Thus Carl had learnt to play out the role of a good sociable patient, which did not represent his own thoughts and feelings. However, Carl's game playing was not effective. During the observation of ward rounds it became apparent that staff were aware that Carl felt he was erroneously detained in the unit, and that due to his lack of insight they struggled with progressing him towards discharge.

Carl perceived that to spend time alone could be construed by clinicians as being antisocial which might then lead to his risk status being elevated. Carl's perception might be interpreted in the context of his diagnosis of antisocial personality disorder. Carl might have expected ward staff to interpret his actions according to his diagnosis. Thus he behaved in a way that was intended to counter the label that he had been given and acted in a social rather than an antisocial manner. Thus, being seen to be interacting and being sociable was understood by Carl to be constructed by the observing ward staff as an indicator of wellness or low risk. Carl believed that crude measures of sociability were used as risk indicators by ward staff. The service users' perception that the observation of sociable behaviour would be used to inform assessment and MDT decision making was validated by the nursing ward round feedback which focussed on nurses' observations and opinions of service users' behaviours (see section 7.2).

The notion that frustration needed to be concealed by service users in order to achieve a favourable clinical assessment was also expressed by other service user research participants. They frequently associated negative clinical assessment with making complaints, particularly when using the formal complaints procedure. During participant observation, Sam, a service user participant described his belief that he needed to contain his frustration with the treatment that he received in order to allow progress towards discharge to happen. Sam described how he managed his dissatisfaction with the care that he was receiving. He believed that it would be detrimental to him to make a complaint whilst an in-patient. Instead, he maintained a record, believing that once discharged he will be able to safely lodge his complaints.

When I get out I will write a list, this and that, this and that [demonstrates a list down his arm]. But I keep quiet, I am compliant ... If I say anything then I am arguing, then I am argumentative so I keep my mouth shut.

(Sam, service user: observation)

Sam was concerned that any complaint or expression of frustration that he made whilst an in-patient could be pathologised by service providers. He feared that complaining might be constructed by service providers as one of his problematic traits rather than being taken as an indication of service failures. Thus Sam was worried that he might be labelled by service providers as being difficult, which could negatively affect his relationship with ward staff and potentially hinder his progress towards discharge. For Sam the complaints procedure acted as a mechanism of regulation, which articulated the demand characteristics of the service rather than providing a safe route to raise concerns regarding his treatment.

Dissatisfaction or frustration with care was perceived by Sam as being used by service providers as an indicator of a deterioration in mental state and would result in an increased risk status. Sam was worried that making a complaint could jeopardise the progress that he has managed to make and so decided to protect his risk status through self-censorship. Thus, Sam seemed to consider the progress that he has already made whilst in the unit as precious and fragile. All his good work could be undone by making a complaint. He needed to sacrifice his comfort and his sense of self

as an autonomous and assertive person in order to protect the status that he has built. He attempted to rescue and preserve a sense of self-determination by planning to assert his rights post-discharge, rather than losing hope and believing that it would be impossible to complain about his current circumstances.

The association between service users voicing dissent or dissatisfaction with care and the risk status that they are afforded by the MDT is illustrated by a discussion that was observed to take place within a ward round meeting. The discussion indicated that service providers expected service users to self-censor and preserve the social order rather than voice dissent which would potentially increase their risk status. The SPR (Logan) (Specialist Registrar doctor) asked whether any of the service users had complained about the unit-wide suspension of leave. Leave to go outside the unit was suspended for all service users in the wake of the publication of the homicide inquiry report. He then interrupted the nurse (Corinne) who had begun to answer his question. He stated in a matter of fact manner that should any service user express dissatisfaction with their care it would be considered a risk indicator and as such used to inform their risk assessment. Thus Logan dismissed the Corrine's voice and made the assumption that there could be no other interpretation of the risk factors. By implication Logan was conveying the view that service users would not complain even when apparently unfair blanket rules were imposed upon them.

Logan (doctor): *anyone report dissatisfaction about change in leaves?*

Corrine (nurse): *they explained to him ...* [SPR interrupts]

Logan (doctor): *dissatisfaction is a risk indicator.*

Logan also brought into focus the organisational assumptions that underpinned service users' clinical progress. The expression of frustration, and being non-compliant with care were coded as risk indicators by clinicians using the Trust risk assessment tool. A reduction of risk indicators was required in order for a service user to be judged to have made an improvement in their risk status which would allow them to move safely towards being discharged from the forensic service. In consequence expressions of dissent were likely to result in the imposition of greater restriction of freedoms imposed

with the aim of optimising risk management. Thus, behaviours associated with demonstrating compliance and described by some service user participants as playing the game were unintentionally promoted by the formal risk assessment processes used within the service. These risk assessment processes maintained the social order of the forensic service, by promoting compliance. Thus risk assessment provided a powerful if unarticulated means of regulating service users' communication. The processes of risk assessment, silencing and the maintenance of the social order within the forensic service may be mapped against the balance of public safety and service user autonomy. Dissent was formally associated with clinical risk, and risk to the social structure within and without the forensic service.

The rules of silencing and the risk game played out between service users and providers were observed to be largely tacit and implied. However, during a crisis, a service user verbalised what he understood the rules of the game to be. During a period of participant observation, I was informed by nursing staff that an incident had taken place on the ward that I was observing. One service user was observed by a member of the nursing team to push another service user out of his way in order to pass through a door way and leave the ward. The same day, an extraordinary meeting of the ward based members of the MDT (ward doctors, ward manager, OT) was convened on the ward to review the care plan of the service user who was believed to be responsible for the incident. The data presented here were collected during the observation of the MDT meeting. Once a discussion had taken place between the members of the MDT and a decision made as how to deal with the situation, the service user (Jason) who was deemed to be the protagonist, was brought into the meeting room to be informed of the outcome of the meeting. Jason had spoken with several members of the nursing team before the meeting, and so was aware that he had been labelled as the aggressor. He expected to have his privileges limited or removed by the MDT. In preparation for the meeting, he had canvassed the support of the nursing team, and also rehearsed his defence with them, providing reasons as to why the incident might be considered to be the other service user's fault. In particular, he argued that he had been provoked by the unreasonable behaviour of the other service user.

Jason walked into the meeting room looking self assured. He was invited to sit down by the doctor (Marion), who was chairing the meeting. Members of the MDT were sitting

in a circle in the room, quiet after the discussion that had previously taken place. Only the chair of the meeting spoke to Jason as it was the convention that the chair spoke for the MDT, and conveyed the decision that they had made to the service user concerned. The purpose of the meeting with Jason was not to discuss the incident with him, but to inform him of what changes had been made to his plan of care.

Jason: how do you know I am not going to do something again? How long are you going to keep me here? [smile]

Marion (doctor): We need to understand what happened and how best to manage risk. None of us have a crystal ball ...

Jason: I am clean shaven, well dressed and ready to go out and then a person like that puts a member of staff and delivery person at risk ... I had two buses to catch. I was in the airlock, an idiot holding onto the door when he has been told twice to let go, insulting someone due to religion. I stupidly pushed the door too hard. The nurse was disappointed in me because I put her in an impossible position. I pushed a patient who was being insulting.

[Marion informs Jason that the team has decided to suspend his leave from the ward for 24 hours. The decision will be reviewed once the 24 hour period has been completed.]

Marion (doctor): please don't see this as punitive

Jason: you have been over the top and harsh. There's no animosity from me or him. I've kept my mouth shut and engaged. I have been on the shop floor so you can write notes about me. Now you are going to be analysing me tomorrow and give me my leave back if I am good.

Jason appeared annoyed with the situation, and immediately challenged the team, even before he was informed of the decision that had been made. Jason voiced his dissent, and questioned the validity of the risk assessment that he believed underpinned his continued detention. By default he was challenging any decision to remove privileges, as they were overshadowed by his challenge to his continued detention. If the premise for his continued detention was flawed then the removal of his

privileges was even more so. Jason appeared to be torn between his desire to express himself and the need to appear compliant.

To challenge the decision made by the MDT, Jason provided evidence that he had behaved in a manner which he perceived to be reasonable and responsible. One of the behaviours that he listed was his self-censorship. He had kept his mouth shut, during his admission, he had not complained, nor exposed the problems within the service. He also described conforming to perceived requirements to engage with therapy and activities, as well as making himself visible and available for assessment. Thus, Jason seemed to articulate his understanding of a tacit agreement between himself as a service user and the service providers. From Jason's perspective, the contract had been breached by the service providers. Jason made an implied threat that, as the service providers have not kept up their side of the bargain that he might not act as a good service user in the future.

Jason explained that he had made himself available for examination, modified his behaviour and censored his speech in order to meet the perceived expectations of the assessing MDT. In return Jason expected that his progress towards discharge promoted. Therefore, he felt angry that his past good behaviour had not been taken into account by the MDT when they decided how to respond to the incident that Jason had been involved in. In this instance a single error was not tolerated by the MDT despite previous demonstrations of conformity. Jason's risk status was increased and his freedoms limited.

Jason attempted to normalise his behaviour during the incident, and thus prevent it from being pathologised. He described the other service user's behaviour as being unreasonable, thus justify his own response. He also explained that he was in a rush, to get something important done outside of the unit. In this way, he perhaps attempted to distance himself from the service user label and so elevate his status. Jason also tried to minimise the seriousness of the incident, stating that there were no bad feelings between himself and the individual. He had taken an active role and pre-empted the MDT by talking to the other service user who was involved with the incident. Thus he had sought to address the issue of potential risk of future violence occurring between them. Jason was attempting to convey to the MDT that he had been able to resolve the problem, and so had utilised the skills that he would have been taught in therapy.

However, he ran the risk of being seen to impinge upon the role of the MDT by overstepping his role as a service user. His leave was removed.

Jason's understanding of the MDT requirements to allow transition towards discharge back to the community was somewhat verified by the comments made by Kamal, an Occupational Therapist. During a formal interview with Kamal the researcher commented on his involvement in MDT meetings with risk assessments for service users requesting to self cater. He explained that his involvement in the risk assessment of service users referred for cooking activities were primarily driven by his concern for his own welfare.

That's where I would be most at risk. Its sort of self-preservation more than anything else! (Kamal, occupational therapist: interview)

A kitchen is a potentially dangerous area, with access to gas and hot water, and so for Kamal the risk assessment of service users' kitchen access was particularly important. Kamal's response also indicated that risk assessment might be informed by personal factors as well as the Trust risk assessment guidance. Therefore the researcher asked him in the context of his role as a member of the MDT to describe how he understood the process of risk assessment.

Its mainly mental state ... because if you don't know what they're thinking, if they're gonna respond to voices, they could self harm or harm you ... That's the first block, the next block is their engagement with you, so how do they respond to you, how do they react to you, how do they react to their fellow people, how do they react to their carers, people who you would assume they would respect, or value? How do they react to themselves, do they respect themselves? ... How kempt are they, all those little things that would be the next filter... It's sort of subconscious. It's sort of, tick tick tick, this is who he is and this is how he's presenting ... I am sure you have seen that there is a hierarchy... The first filter would be can they actually enter the kitchen and the second stage is what do they have access to, and the third stage is how much supervision do they require. (Kamal, occupational therapist: interview)

Kamal's description of risk assessment as using different levels of filter suggested that the assessment took place in a stepwise fashion. If a service user was withholding information or was actively psychotic then they would not progress to the second stage of the assessment, and kitchen access would be denied. Thus, he viewed service user social behaviours firstly in terms of individuals' pathology. Kamal's description of the risk assessment process revealed that he had constructed a personal and tacit risk assessment tool which he drew upon to make decisions regarding risk management. Kamal's risk assessment tool had mental state as the most reliable indicator of risk, with signs and symptoms of mental illness used as risk factors. Medical factors were privileged within Kamal's risk framework, which, by implication, made the psychiatrist the primary expert in risk assessment. For service users to be assessed as ready to be given kitchen access they must not only be assessed as having a suitable mental state but also be relied upon to communicate their symptoms, and open their thoughts to service providers. Therefore service users must conform to organisational processes and freely communicate their innermost thoughts and feelings in order to be allowed greater independence.

Kamal confirmed many of the beliefs regarding assessment that Jason expressed during the MDT meeting. Kamal identified observation and interpretation of interaction as the first and thus the most important stage of assessment. He categorised the assessment of interaction into three parts according to who the interaction was with. Interaction was categorised as being with the assessor, peers, carers; people who it might be assumed that the user would respect and also with the user's actions towards their self. This list of categories of interaction indicates that there was an expectation that service users would behave and communicate differently with different groups of people. However it is unclear how the expected difference in communication was interpreted within the risk assessment process. Furthermore, Kamal's description highlights the importance of non-verbal as well as verbal communication in the assessment process. Service users must be aware not only of what they are saying and to whom but also of their more subtle non-verbal communications. It is unclear whether the list is understood to be a way of building up a picture of the individual in different contexts or a way of checking out the reliability of service user behaviours. Kamal might be checking whether service user behaviours are the same when they know they are being observed and when they are not aware of being observed. Thus

he would be seeking to catch out service users who are playing the game. The separation of self and behaviour might be interpreted as Kamal separating the individual from their offending behaviour, to retain a sense of something good being present in the individual or as mistrust in service user behaviour as an indication of thoughts and feelings and a belief that service users are playing the game and so being deceptive. The list of interactions given by Kamal could be also interpreted as being hierarchical, with the individual's interactions with the assessor being the most important factor and interaction with themselves, and self-respect being the least.

The second stage or filter includes an assessment of the individual's physical appearance; thus validating Jason's perception that keeping himself clean and well dressed met risk assessment requirements and therefore enable him to progress towards discharge.

Kamal described using a subconscious checklist to inform his risk assessments. As the checklist was subconscious it was not articulated to service users who must therefore attempt to discover what was being assessed and alter their behaviours to meet service provider checklists. Furthermore as the checklist was subconscious it might be assumed that the checklist will be informed by Kamal's past experiences and beliefs as well as the Trust risk assessment forms. Thus service users must tap into and influence a tacit and potentially idiosyncratic decision making process that service providers may not themselves always be able to articulate. Therefore service users would need to alter their behaviour to meet other individual clinician's checklists, and would risk being perceived as being duplicitous as their communications might be observed to be different with different people, thus making risk assessments based on observations unreliable. Kamal also separated the individual from their behaviour or presentation. The distinction that Kamal makes may be interpreted as Kamal believing that there is disjuncture between a service users' behaviour and the self, or risk.

Unlike the service user participants previously referred to, such as Martin and Tony who appeared reluctant to openly discuss playing the game, Jason discussed his interpretation of the game rules with service providers. Furthermore Jason discussed the game rules with the very clinicians whose assessment he is attempting to influence

by playing the game. Thus Jason has made the seemingly unspeakable spoken, and seems to be challenging the legitimacy of members of the MDT whom he considers to be acting oppressively. Jason's challenge appears far from revelatory for the service providers and it seems possible that the MDT is colluding with the service user to promote his discharge. Thus the game appears to meet service provider as well as user needs.

6.3.1 Game playing as a dynamic process

Service user participants described the relationship between service users who were playing the game and service providers as being a dynamic one. Therefore service users did not see themselves as being sole players in the game.

As data previously discussed in section 6.2 Jason's response to the MDT decision indicates that he perceived the decision not only to be punitive but also unfair. His anger indicates the existence of an unspoken contract with the MDT which he believed the MDT has breached. If he behaved in a manner acceptable to the team (he has kept [his] mouth shut and engaged), then he would progress towards discharge and be given greater freedom. However, following the incident his freedom has been limited. He feels that counter to judicial sentencing his past good behaviour was not taken into account by the MDT when they made their decision to suspend his leave. Thus from Jason's perspective, the expectation of fair play by the MDT has not been met. The fragility of the progress that Jason has made towards being discharged, is exposed, one misdemeanour and progress is halted, perhaps undone.

Jason was sarcastic about the 24 hour suspension of leave. Again he must be assessed, and if he conforms as he has done before he will be given his leave back.

Now you are going to be analysing me tomorrow and give me my leave back if I am a good!

(Jason, service user: observation)

Jason refers to his behaviour as being good. He is being sarcastic but he is also letting the MDT know that he was playing the game; that he will do as they ask but his behaviour would not be an indication of a change in his mindset. Jason's articulation of the logic underlying the MDT decision was an act of defiance, a response to his perception of being punished by the MDT. He will play the game and take his punishment in order to have his leave restored. Thus he openly voiced his defiance of the system to the MDT, asserting that he was in control of his assessment and is mocking the system of analysis upon which the decisions of the MDT are apparently based. However he was also highlighting and reinforcing the difference in status between himself and the MDT. He had named and exposed the game. Jason expressed a sense of injustice with the situation, but stated that he would be good; he would show deference to the MDT in order to have his leave reinstated.

Despite voicing his dissatisfaction with the system and the MDT in particular, Jason conformed to the decision made and after a twenty-four hour period of assessment his leave was returned.

An indication of service providers being complicit in game playing by service users was highlighted in clinical decisions made by the MDT regarding a service user (Mark) who refused to be sociable with service users and service providers and engage with prescribed activities. During the observation of a ward round Mark had asked to be given unescorted ground leave although he did not have escorted ground leave. He had brought an advocate with him to help him put forward his point of view, as he was at loggerheads with the MDT. Mark refused to believe in what he called Western medicine and so refused to conform to organisational regimes, thereby declining to adopt the prescribed route for exiting from high risk status. Mark stated that he would not run away as he knew that the police would bring him back. Thus Mark was arguing that he did not represent a risk even though he had not accepted the legitimacy of the risk management regime. Furthermore absconding may be considered a second removed adverse outcome in relation to harming others, which is the primary concern. However, despite this the ward manager kept to the view that he would prefer Mark to engage in activities before being given unescorted leave.

Mark: *I don't want to do activity, I don't want to talk to other people, I don't want to walk around the hospital with a nurse*

Delia (doctor): *but that is exactly what leave is!*

Mark: *I have been here for six or seven months*

Phillip (RMO): *what would make us relax is if you went to things, activities*

Mark: *why should I do that?*

Phillip (RMO): *to get what you want.*

The doctor (Delia) and the consultant psychiatrist who was Mark's RMO (Phillip) made no movement towards Mark's point of view which challenged the underlying rationale of their approach. Delia and Phillip's view was that the only acceptable understanding of the leave process was that of the MDT. As both parties were in deadlock Phillip changed tack. He attempted to coax Mark to change his behaviour without agreeing to accept the prescribed exit route. Phillip explained that the motivation for Mark to engage in therapy was to get what he wanted. Thus Phillip indicated that engaging in therapy didn't mean that Mark had to accept that he was unwell and required therapy; rather it was a strategic manoeuvre that would aid his progress towards discharge. Phillip also stated that Mark's engagement in therapy would help the team to relax. This statement could be interpreted that through engaging in activities that Mark will enable the team to protect themselves as the boxes required for risk assessment would be ticked, thus avoiding criticism of the MDT if they were to give him leave. Therefore it would appear that Phillip was openly instructing Mark in how to play the game, and articulating the gain for both the service user and the service provider. However, it was unclear whether Phillip was colluding with Mark in order to get him to engage in therapy, in the belief that therapy would have an impact upon his level of insight into his mental health problems or whether he was openly playing the game.

Thus it would appear that in this case at least, what was required by the MDT to allow service users greater freedom was conformity to organisational processes, in this case

graded leave, rather than a change in mental state. The potential gains for service providers engaging with game playing are indicated in data captured during a formal interview with a service provider (therapist) research participant. Max described his perception of how both service users and clinicians benefited from not engaging with deep psychological issues that the service user might have.

I think there are limitations within the service in terms of resources, don't have the time in hospital, to address the issues ... The length of the stay is generally thought to be two years, and I don't think you can really get to grips with some of the deep-rooted stuff in that period of time ... Most of the people I have come across here have been very reluctant to, to acknowledge and think about past difficulties because this is too painful. And they feel that if they get in touch with their feelings they are gonna become unwell again, and angry or violent, and that will keep them in hospital for longer. So ... they'd much rather say, "Well I was psychotic", or "I was drunk", or "I was on drugs" because that's saying it's easier to think, "Well, if I don't take drugs then I won't do anything wrong again". It doesn't work like that as far as I'm concerned. (Max, therapist: interview)

Max described the service from a psychotherapeutic perspective. In Max's view, therapy for the "deep rooted stuff" would take longer than the expected average two year length of stay for service users within the medium secure service. The unit was developed using the premise that service users would only be expected to reside in medium secure units for eighteen months to two years, whilst being rehabilitated and returned to the community (Butler 1975). Therefore the service was resourced for and is organised around a two year stay even though users could be detained within the service for much longer (see section 1.7 for a fuller discussion).

Service users were expected to participate in the process of rehabilitation and develop the skills required for reintegration back to the community. However engaging with therapy and exploring issues relating to their mental state and offending behaviour might reveal additional risk factors. Thus, engaging with therapy carried the risk of service users being placed in a higher risk category. Therapy might then delay rather than expedite the discharge process, which would be problematic for the service as

well as the service user. Consensual silencing by organisation and service users enables simplification of the system of risk assessment and therapy. Risks such as re-offending that cannot be readily determined are simplified and proceduralised making the business of forensic mental health achievable.

Max seemed to describe consensual silencing by service users and providers which offered the twin gains of maintaining the through-put that the service required and achieving the discharge that the service users desired. The service users were perceived by Max to be complicit in the avoidance of dealing with underlying psychological problems due to their fear of confronting issues that they have managed through avoidance and repression. The quick and painless fix offered by the tacit medical/compliance model is a much more attractive option than prolonging admission and confronting deep seated fears. Service users were given an alibi for their behaviour (it was the drugs, not me) and the non-communication of symptoms and risk factors enabled the organisation to function in an apparently efficient manner. However non-communication also put the organisation at risk from serious untoward incidents occurring due to unknown and unmanaged risk indicators.

The cans of worms that Max described were the service users' psychological and social difficulties which were left largely untouched during their stay within the forensic service. In not addressing these problems, the medical model was privileged over other forms of therapy such as psychotherapy. Instead of utilising talking therapies, crude, easily measured behavioural risk indicators such as the use of drugs or alcohol were adopted for expediency.

Thus Max, like Kamal, separated the service user self from their behaviour. Max saw the acts as being driven by the self. The self was hidden behind the behavioural explanation used by the service. For Max in order to deal with the offending behaviour, the self must be engaged in treatment rather obscured by a focus on more easily measured behaviours.

6.3.2 Problems encountered by service users when playing the game

Despite Max's description of the relationship between service user organisational needs being complimentary, tensions were found to exist between continuous assessment and game playing, which proved to have a complex and problematic relationship. The issues that arose from the analysis of the data are listed below. These issues are further discussed in chapter eight in relation to internal and external organisational factors. In this section the data will be used to explore and elucidate the conflicts identified.

- Service users playing the game needed to be mindful of when and to whom they were playing the game.
- Service provider acceptance that the behaviour of a service user could be relied upon to inform assessment was vital for the success of the game. If service users were not skilled at playing the game they risked giving the game away with the result that service providers could potentially become distrustful of their behaviour.
- Game playing could have a negative impact upon relationships, with peers and therapeutic relationships with service providers.
- Service users risked fully adopting the institutional role and losing their connection with their sense of self within the community.
- Game playing could impact negatively on service users' mental health.

The presentation of self and the ability to influence the perception of others proved to be particularly problematic for three service user participants, Clive, Sasha and Tony.

During the participant observation of ward activities, the researcher engaged in a discussion with a group of service users about violence and killings that had been reported in the media as happening between groups of young men within the local community. One service user commented that he believed that one of the reasons for the violence was the need for the person to prove that they were 'real' and not 'fake'. To carry a gun and not use it risked the individual being labelled as a 'fake' by members of their peer group. Therefore it would seem that being fake was to talk in one way and act in another. The researcher then asked the service users to explain what they understood being fake was. They responded by making parallels with the labels of 'real' and 'fake' with their current status as an inpatient.

Clive: being fake is being different in different places.

Researcher: aren't we all like that?

Sasha: yes, I am a fake here. Its who you are at home

Tony: I am not a fake!

Clive described his understanding of the label fake as depicting an individual not being consistent in their behaviour, irrespective of the situation or environment. Clive seemed to describe the existence of a self that consciously drives the behaviour or performance of the individual regardless of their social context or frame.

The researcher then commented to the effect that everyone modifies their behaviour according to the situation or social context. Sasha seemed to identify with my comment. He acknowledged behaving differently whilst detained in the unit, and identified his real self to be who he was at home. Thus home may be thought of as a safe space where an individual may control the interactions that take place, unlike those that take place within the secure unit. At home Sasha was safe to be himself. He could not be his real self when in the unit, and so became a self which he labelled as fake. Like Carl and Martin, Sasha seemed to be actively controlling his behaviour in order to present himself in a manner that is expected to meet with the service providers' approval and promote progress through the care pathway. Thus modifying behaviour and censoring voice, becomes understood as creating a different, fake self.

During the discussion Tony abruptly declared that he is not a fake, and then left the group, a move which ended the discussion. Tony appeared to be insulted by the suggestion that he was fake. To openly admit to being fake could potentially have had negative consequences for him, both socially, within his peer group and also regarding his formal assessment, and treatment. The discovery of an individual manipulating or faking their presentation could negate an assessment that has already been completed, and therefore slow the progress towards discharge. Also trust within the therapeutic relationship would be broken. Thus, Tony's verbal and physical distancing from the group discussion seemed to flag up the potential dangers for the service users in openly talking about their manipulation of their presentation whilst being assessed. In response the group self-censored and either left the area physically or changed the topic of discussion. It was not possible to ask Tony why he had left the discussion as he had clearly indicated that he was annoyed with the conversation and did not wish to continue to be part of it.

The notion of being real or being fake also impacted on service users' perceptions of ward staff. During a period of observation the researcher made a comment that she had observed the ward staff to be friendly with the service users. Sam, a service user strongly disagreed with the researcher's observation, describing the friendly manner of the staff to be part of their job.

Researcher: *the staff are friendly*

Sam: *No they are not! Not friendly*

Researcher: *I saw you laughing and joking with them the other day*

Sam: *Maybe just two, but not that friendly no*

Researcher: *then how would you describe it?*

Sam: *they are doing their jobs.*

Sam was careful about how friendly he was with the ward staff. He was mindful that they were not his friends, and when being friendly towards him they were only doing their jobs. The apparently friendly interaction and amicable nature of the staff was perceived by Sam to be fake. It could be interpreted that Sam understood the interaction that he was observed to have with ward staff as being part of the game. He and the ward staff were both interacting in a friendly manner. However the staff were doing their jobs of collecting information and Sam was being superficially polite in response.

Maintaining a connection with an identity external to the unit was vital for service user participants who were actively playing the game. In the absence of a separate identity, service users risked roles becoming trapped in a compliant role. The importance of keeping in touch with the world outside the unit and maintaining an identity other than that of a service user was described by a service user participant (Mark) during participant observation. During the observation of a ward smoking break, Mark asked the researcher what she was hoping to achieve with the research she was undertaking. The researcher told him about some of the initial findings that related to the service user experience, including how service users seemed to spend time waiting. He responded by describing how he regulated his communication when spending time in ward areas that were under the surveillance of service providers. He described displacing his voice to pockets of safe space away from the gaze of the service providers where he could openly communicate with other service users and maintain his community identity.

Here the patients help each other, don't trust the doctors and nurses. They are authority figures. The patients meet in the evenings and talk about what happens day to day, keep in touch with reality, with our reality and the outside world.

(Mark, service user: observation)

It would seem that, for Mark, there was more than one reality inside the medium secure unit. There was a formal reality that existed under the surveillance of service providers, one which he inhabited during the day. A second, personal reality existed after hours, a reality that was formed through the maintenance of a community identity that was

independent of the unit and existed prior to his admission. He kept his external identity alive through meeting with other service users during the evening. As with Sasha, Mark's personal reality existed outside of the unit. Thus, Mark did not consider the self that he presented to staff to be real; he could only become himself when he was with other service users, in a situation where he wouldn't be scrutinised. There would seem to be a fear for Mark that his outside reality might be lost, by becoming subsumed within institutional systems. The evening meetings preserved the service user reality and acted as a form of underground resistance to that created by the forensic service and service providers. Mark's description echoes Goffman's secondary adjustment; Mark circumvents and subverts organisational systems, through the creation of an *underlife*, away from areas of surveillance (Goffman 1961).

Mark was describing his management of the presentation of self and role distance. He was playing the role of a service user but also distancing himself from the 'virtual self' that he associated with the role.

Service users did not always maintain outward compliance. They were also observed to threaten to expose failings in the service in order to be listened to and have their complaints addressed. During an informal discussion between service users and ward staff, Kurtis threatened to inform the press that service users had to pay to see the dentist.

I have heard patients need to pay for dental care, I am going to the press!

(Kurtis, service user: observation)

The ward staff responded in a dismissive manner. However, the matter was later addressed in a managerial meeting and free access to dental care was reinstated. On another occasion, when a serious untoward incident had occurred, a ward manager had commented that service users had contacted the press and told them what was happening. Thus, whilst service users largely silenced their complaints and displaced voice, they also held power to make public problems within the service, and thereby threatened the organisation's reputation. It was unclear what motivated certain service

users to invoke the press whilst others chose to remain silent. However, the service users who went to the press were often labelled by ward staff as being difficult and non-compliant. Thus it would seem that certain service users refused to play the game, instead choosing to challenge the system head on. As noted above, some patients exhibited ambivalence about playing the game, appearing torn between trying to reduce their risk status in this way and expressing personal autonomy.

Sitting and waiting also brought problems for service users of becoming de-motivated.

Service user: Its like being in a waiting room, the more you wait the less you do. It can't be helped, all wards are the same.

Researcher: It decreases your motivation?

Service user: Yes!

Sitting waiting seemed to have an adverse affect on service users' mental state. Thus, ironically, sitting and waiting could potentially cause service users to be viewed as more risky. Service users needed to comply with inactivity to be judged lower risk, but the tedium may damage their mental health, potentially leading to behaviour which would be classified as a higher risk. To successfully play the game, users must accomplish quietly doing time, which should reduce their risk status but not necessarily their propensity to reoffend.

6.3.3 Problems for service providers with playing the game and assessing risk

Service-provider participants described finding it problematic to employ the heuristic devices that they would normally rely upon when assessing the risk of an individual that they suspected of feigning compliance. If unable to confidently assess risk, detention might be prolonged, with service providers maintaining service users in a restrictive environment until evidence that is considered to be more reliable could be obtained.

The complexities involved in assessing a service user's behaviour and risk is raised in the analysis of the data below. The data presented were collected during a ward round discussion. The members of the MDT were discussing a service user's risk assessment and the possibility of discharging him back to the community. The doctor (Callum), who was the service user's RMO (Responsible Medical Officer) talked about the difficulties that he was having in trusting the veracity of the service user's presentation. By adopting a sarcastic tone, Callum powerfully conveyed his concerns to the team. The reliability of the assessment of risk that had been undertaken was placed into doubt, rendering decision making regarding the planning of care and associated risk taking problematic.

Insight is interesting, won't kill anyone again, might stab someone, might throw a cup of boiling water but not the whole kettle! Is it cognitive? There is no empathy or connection with the person. He knows the right things to say, whether we ever get past this or recommend whether to ever move on.

(Callum, doctor: observation)

Callum voices uncertainty about whether staff can trust what the service user says. He was unsure as to whether the information that the team has gathered could be relied upon to inform the processes of risk assessment and decision making. The difficulty for Callum was uncertainty as to whether the service user's voice may be trusted as an external reflection of their inner thought processes and intentions or whether it was merely a surface response that has been employed by the service user to influence the assessment process. There was a concern that the risk business had been superficially learnt by the service user, i.e. that he was game playing, and that there was no evidence of victim empathy. Callum questioned the cognitive ability of the service user to learn what was required for them to be safely discharged. He then expressed his concern that the service user's progress along the clinical pathway may become stalled because he couldn't persuade clinicians to trust that his compliance indicated low risk. Thus, paradoxically, by being seen to play the game service users risked creating mistrust within the MDT, a situation that they could not easily retrieve once doubts had been raised. Furthermore by failing to challenge the system and silencing their dissent, the service users were preserving and strengthening the social order. Thus the service users could find themselves in a difficult situation. Not to complain perpetuates stigma

and disempowerment, but they perceived that challenging the system was likely to result in them encountering difficulties in reducing their risk status. It might not be reasonable to expect that current service users will be concerned with the future development of the forensic service, particularly in circumstances where to express their concerns might result in their personal progress being jeopardised. It is also problematic for compliance to be treated as an indicator of clinical progress, as for the service user to demonstrate compliance indicators of inner mental state are blocked off and emotional engagement with service providers is avoided. In playing the silencing game the process of recovery was potentially subverted with the service user not developing the skills required for successful integration back into the community upon discharge.

6.4 Conclusions

The analysis of the data revealed that institutional processes had been mapped onto risk, with service user conformity being conflated into an indicator of riskiness. These processes could include therapy which some service users associated with an increase in their risk status and continued detention. Therefore there was little incentive for service users and providers to engage in therapy. Instead, some service users engaged in game playing with service providers rather than therapy to hasten their progress towards discharge.

Service users attempt to discover and respond to the requirements of the risk assessment process. Risk factors may not be clearly articulated, and may differ according to the interpretation of the service providers who observe and assess service users. In response service users develop their own methods of understanding institutional risk assessment processes, and respond accordingly. The interpretation of assessment processes and service user responses may be conceptualised as a game of risk assessment and management whereby service users attempt to manage their own risk status in order to hasten their progress towards discharge. Game playing was found to be complex, and service users needed to be skilled at detecting and responding to cues from service providers.

One way that service users were found to modify communication was through the silencing of complaint. The voicing of frustration or dissent was often associated with riskiness. Furthermore, complaints challenged the simplification of organisational systems of risk assessment and management. Silencing, for example tolerating the violation of social norms governing everyday behaviour, and compliance with organisational processes were superimposed on risk assessment and management. The risk focus nominally on re-offending after discharge becomes obscured. Although this process was combined with risk assessment using formal 'tools', the latter provided limited guidance because the items either referenced unalterable biographical factors or themselves relied on situated social judgements, e.g. of 'insight'. The mission of the forensic service is a problematic one, as clinicians must assess the service users' behaviour whilst residing within a secure service, and estimate potential threat that the service user might pose to the community upon discharge. However, the ecology of the secure environment in which service users behaviours are assessed is very different to that of the community. In consequence it is problematic to extrapolate service user behaviour in the community on the basis of what is known about their behaviour whilst resident within secure services. Staff may have used the dubious risk assessment processes outlined in this chapter because nothing better was available. Compliance provides clinicians with something tangible to work with, something measurable, and readily understood by the public, unlike the concept of risk.

There was some apparent collusion between service users and service providers although game playing was not officially supported by the organisation. Clinicians sought to discover duplicitous behaviour whilst also encouraging service users, perhaps unintentionally, to only superficially engage with therapy. However, game playing was also found to be problematic as it resulted in an avoidance of therapy by service users, limiting the extent to which underlying social and psychological problems could be addressed.

Furthermore, the regulation of communication was found to be problematic for some service users as they needed to perform the role of the compliant patient whilst still preserving their sense of identity. Service users also needed to contain or find an outlet for frustrations arising from tolerating unresolved problems or feelings of dissatisfaction. Therefore voice was displaced to safe spaces which were relatively free from surveillance. Thus some service users were able to retain a sense of self

separate from the organisation through affirmation by peers. Talking with other service users enabled them to maintain a sense of self separate from that of a service user, and a mental connection with their outside community. Service users were also able to vent feelings of frustration as well as express views that they believed if spoken in front of service providers would negatively impact on their risk status and so hinder their progress towards discharge. Therefore, some service users attempted to mentally maintain community connections whilst performing the role of a complaint patient.

The game of risk management in the forensic service observed was found to be strained as the organisation was subject to internal and external review. The organisation needed to account for past practice and whilst doing so was under pressure from within the Trust to prevent further untoward incidents occurring. Officially unsanctioned, game playing enabled the mission of the organisation to be protected by the illusion of a seemingly efficient service. Paradoxically game playing left the service open to future incident and investigation as service users learnt to project a persona of a compliant individual that satisfied the risk assessment criteria and reduced their risk status. Also the communication of risk factors and problems by service users was stymied, which meant that the organisation was unable to respond to them unless an incident occurred.

There is some resonance with Goffman's work with care not being centred on individual service users but upon the service users' conformity with organisational norms. However, half a century after *Asylums* was published, in a more risk averse society the process of institutionalisation is provided by processes of risk assessment and management (Goffman 1961).

Chapter 7

Results: The regulation of communication by service providers

7.1 Introduction

This chapter further develops the theory of the regulation of communication, to try to manage risk status. However, the analysis focuses on mental health service providers rather than users. As in chapter six, data will be used to illustrate how service providers modified their communication in an attempt to manage their risk status. It is argued that service providers managed their risk status in order to cope with inherent role conflicts, to try to avoid blame and protect their employment.

As previously discussed in section 1.7, the mission of forensic mental health care is problematic, with services seeking to ensure public safety whilst also promoting service user autonomy and enabling service users to reintegrate back into the community. Forensic mental health services are under pressure from consumers, both service users and the public to meet their potentially conflicting needs to provide containment and safety as well as take risks and promote reintegration of mentally ill offenders back to the community. This conflict has been found to cause role tensions and stress for forensic mental health service providers, which may put the organisation under pressure (Mason 2002). At the time of data collection the research site was placed under threat of closure following the publication of a damning homicide inquiry report. The service then came under pressure from external and internal review and increased regulation by the Department of Health and the Home Office, which then affected communication within the organisation.

Data will be used to explore the regulation of communication by service providers within organisational systems. Communications will be crudely categorised as occurring within formal and informal organisational realms, which are externally imposed or internally generated. The term 'informal' will be used to describe communications which occur on the edges of formal organisational business and which do not conform to formal organisational rules or boundaries, for example conversations that are held off record.

The chapter will outline how the regulation of communication within the organisation occurred in the context of a complex system of formal systems and informal groups and networks with particular reference to the attempted management of risk status. The interplay between formal systems and informal groups will be examined. In particular the data will be used to show how service providers regulated their communication in response to perceived threats to personal or collective identity. The data are used to outline how communication was regulated through mechanisms of self-censorship, the modification of the content of communication and the re-direction of message.

Self-censorship resulting in the 'absence' of communication can only be identified directly in relation to culturally derived expectations which are themselves variable, negotiable and ill-defined. Therefore data were largely drawn from participants' self reports both in formal interviews and informal discussions that took place during periods of observation. However, during data collection, it became apparent that self-censorship and voice were context specific with informal conversation about activities that were taking part on the ward often revealing quite different attitudes and concerns to direct questioning in formal recorded interviews or the observation of formal organisational processes (see section 4.9). Thus service providers regulated communication according to the organisational and social context of the conversation.

Service provider participants often described choosing to self-censor in response to fears of being subject to disciplinary procedures. In particular, they feared being blamed and subsequently disciplined for failure, and ultimately losing their jobs. From observational and interview data it was also apparent that many service providers regulated expression in informal social networks in order to avoid censure by colleagues. Service providers valued their relationships within peer groups, and regulated or censored their communications in order to maintain relationships and avert perceived threats of their breakdown.

Often factors that influenced the regulation of expression by service providers such as the perception of potential threat to self, over-lapped between informal and formal organisational systems of communication. A strong example of this is the perceived

risk of incurring social and formal organisational censure by making comments that might be considered to be racist. In order to capture the contextual frame of the regulation of communication by service providers, data have been has been categorised and presented according to context, including informal and formal systems. The findings of the study will be discussed under the headings of: The avoidance of blame, silencing challenges to the social order and medical dominance in relation to multidisciplinary team power relationships.

The term staff will be used as well as service providers to describe individuals that work within the forensic mental health services. However the terms are not necessarily interchangeable. Research participants referred to ward based service providers, in particular nurses, as staff. The distinction between ward based staff and other service providers was reinforced by the use of the term shop-floor staff. Thus the term staff was used by research participants to distinguish between non-clinical managers and ward based staff as well as to differentiate between service providers and users. This division is illustrated by a comment made by a research participant during an interview.

I'm talking about ward staff, not managing staff.

(Jack, health care assistant: interview)

Some managers such as ward managers have clinical as well as managerial roles and so potentially straddle this organisational divide. Research participants largely included clinical managers in the ward staff group. However, some clinical managers were also observed to be referred to as managers, by ward nursing staff and excluded from the informal ward staff group discussions. Thus, the categorisation of individuals as staff or managers proved to be problematic as there is some fluidity between the two groups. Furthermore, tension was evident in roles which required solidarity with unit staff, and yet required the individual to fulfil managerial requirements. The management of this tension through the regulation of communication is discussed below.

Therefore broad categories of managerial and front line staff will be used throughout this chapter. Clinical service providers will be referred to as staff, service providers without a clinical role will be referred to as managers or administrators, unless otherwise designated by research participants. The term service providers will be used as a blanket term for all individuals employed within the service.

Central to the chapter is the research participants' perceptions of the organisation's demand characteristics, and service providers' attempts to find their own living space in the organisational environment. Participants' perceptions of organisational demand characteristics were affected by the organisational response the publication of a homicide report which criticised not only the unit but many other aspects of the forensic mental health system. Measures were put in place in order to manage reputational risk, and protect the organisation's problematic mission of maintaining security and promoting recovery. The organisation increased the regulation of service provider behaviour and instigated rituals such as the wearing of belts by service providers. Service providers' interpretation of the organisational response was shaped not only by the information provided by the organisation but also individual, social and professional frames. Interpretation of the messages underlying the organisational response was demonstrated through the regulation of communication by research participants.

The chapter examines the regulation of communication as a means by which individuals responded to the perceived demand characteristics of the organisation. The first section will explore problems inherent to processes of assessment and information sharing. The second section will discuss how individuals directly interacted with organisational regulatory systems. Participants describe how they avoided blame for error, in order to protect themselves against the perceived threat of formal disciplinary action and potential dismissal. The third section will discuss how individuals' responses to the perceived demand characteristics of the organisation were modulated by informal, self forming groups. Pressure exerted by informal groups protected the members of the group from disciplinary measures and preserved the social order. The fourth part of the chapter will focus on the regulation of communication within the multidisciplinary team according to professional power and medical dominance. Medical dominance is considered within the context of research participants' perceptions of the demands of their professional regulatory bodies as well as those of the organisation.

7.2 Problems with information sharing by service providers

On a practical level the communication of information within the multidisciplinary team was problematic. Systems for the recording and sharing of information, by the nursing team involved several different points of communication and interpretation. Thus information communicated to the multidisciplinary team meeting to guide decision making potentially was not always true to original observations or documentation. Furthermore there was also a risk that meaning within the communication might become diluted or distorted on its journey to the MDT decision making forum.

A ward round or multidisciplinary team meeting was held once a week for health and social care professionals to meet and discuss their assessment of service users that are allocated to that team. The service users were not present during the MDT discussion, but were invited to attend towards the end of the meeting in order to be informed of the outcome. Clinical or multidisciplinary teams were aligned to wards. In the meetings, the nurses provided the main source of information about a service user's everyday behaviour. However, nursing accounts of behaviour tended to be formulaic, with nursing feedback being read by a nurse from a standard form that was used across the unit. Unlike the feedback from the other members of the MDT, the nurse representative did not give their own report and was reliant on reading out reports that had been completed by other nurses who were the named nurses for the service user being discussed by the MDT. Notes of service user behaviour and interactions were written daily by various members of the nursing staff, summarised by a different nurse and then read out in the team meeting by different nurse again. Thus nursing notes became akin to Chinese whispers. Therefore information from the nursing team regarding service user behaviour became distilled and lost much of the meaning and reliability. During an interview Marion, a doctor, outlined the problems that she identified with nursing feedback

They [nurses] don't feedback their own feedback, they feedback someone else's feedback, if you know what I mean. So, someone has written those notes and then they have to somehow convey that to us, and to me, that is something that happens throughout, if you work in hospitals, it's like Chinese whispers, it gets distorted inevitably. From what you saw, I'm still learning from an incident that

happened here two weeks ago, that I documented thinking, it was the right documentation. I still learned yesterday and the day before that it happened in a different way, people tried to convey it to you, what happened and I think if you haven't been there and seen it, it's difficult to really translate that into words.

(Marion, doctor: interview)

From Marion's account the communication of nursing observations at the MDT meetings not only lost detail but also potentially became misleading. Individual staff members might have different interpretations of an event, so that even first hand accounts can be unreliable. The only information that Marion believed that she could rely upon was that generated from her own observations. However, the MDT needed to make decisions regarding service users' care and their main source of information were the nursing ward round reports.

In order to address the problems of inconsistency in nurses' reports to the MDT described by Marion, a standard form was used by the nursing team, with the aim of promoting consistency in ward round feedback. However, the use of a standardised nursing feedback was also problematic, with nursing feedback becoming mechanistic. During the observation of MDT meetings the researcher found that the nursing feedback differed little between service users, or from week to week for the same service user. Only when an incident occurred did the nursing feedback become more individualised and colourful. Indeed the nursing feedback became so repetitive across wards and between service users that the researcher began to think of it as a nursing mantra, so much so that when observing ward rounds the researcher began to omit the nurses' report from field notes, giving a shorthand nursing feedback rather than writing out very similar reports. The data below were collected during the observation of a ward round, and provides a typical example of nursing feedback.

Remains stable in mental state, pleasant on approach, no hallucinations, no anger or frustration this week. Spending loads of time in the communal areas lately. [name] has been using ground leave well and has wrapped Christmas presents... (Jemma, nurse: observation)

The report given by Jemma was mechanistic, and used broad, ill-defined terms such as pleasant on approach, terms that nurses and other members of the MDT had often been observed to use. Pleasant on approach encompassed many service users' behaviours which were taken to indicate that they were friendly and compliant. Jemma's account addresses behaviour and does not delve into how the service user might be feeling or thinking.

Jemma reported that the service user's mental state was stable. A stable mental state was constituted as being the absence of certain behaviours such as displays of anger, voicing frustration, and reported experiences of symptoms such as hallucinations. Thus service users must not only manage symptoms of mental health they must also tolerate life within the institution, by not expressing any frustration with their circumstances. Expressing frustrations might include making a complaint about the service, and complaints might be taken into account during the assessment of the individual. A further indicator of risk status used by the MDT was that of the service user being pleasant on approach. The judgement as to whether a service user had been pleasant on approach related to their time spent being sociable in the communal areas of the ward and voicing acceptable views. Thus, the service user participants' perceptions of the behaviours required to reduce risk status previously discussed, seem to be validated.

During the interview with Marion the researcher shared her observations of the nursing feedback and asked Marion for her views.

Its very robotic now... When I do a case conference report, I go through the nurses' feedback, and it's just the same. Sometimes you can see people writing the same things that they had written before. You find things that have been said in the ward round, and the week after, and you think: "That's what you said last week". It's like a monotonous repetition of things, so I find, I think partly because the nurse systems, I think, don't quite grasp sometimes just how valuable that is, they don't feel probably valued in that sense then, so they think; I'm just going to say mood is stable, it has been stable through the week, sleeping well, personal hygiene, blah, blah, blah ... I think they would just miss the point if you just have

to say this, this and that because then you will be looking to tick those boxes and you will miss out on those little important things that you have observed that you think: "May be it is not important but I should tell them, a little human side of things."

(Marion, doctor: interview)

Marion's description reflected the researcher's own observations of the MDT meetings (see below). She described the nursing feedback to be repetitive, meaningless and dull. A tick box approach dictated the focus of nursing observation and reporting rather than the needs of the individual service user. In Marion's view the nursing feedback has become robotic; dehumanised by processes that were put in place to make the organisation function more efficiently. The clinical nursing voice was weakened as unlike the other members of the MDT the nursing team did not present their own work and so often did not draw upon their own professional knowledge base when feeding back to the MDT.

Marion's concern about nursing communication to the MDT was echoed by Kamal, an occupational therapist. The example of problematic communication he provided was of the omission of important information by nursing staff during the daily handover. The daily handover enabled the ward nursing staff, that worked shifts, to provide information to ward based members of the MDT at 9am when they arrived for work. The members of the MDT who attended were generally occupational therapists, ward based doctors and the ward manager although students and therapists were also observed to attend. However, sometimes only the occupational therapists attended the meetings.

There's been one or two occasions where incidents have been - not sure how to phrase this - not fully reported. It's mentioned almost as if in passing, whether that's because the person who got the handover didn't get enough detail about it from the person who observed it, or there is just a lack of interest, or people become passé with things, it's hard to tell. But there can be times where you think well, what happened, someone is secluded, but why and how, sometimes those things just - you can't get that information from the hand over, which is what the

handover is for, is to get that specific a knowledge. So there have been occasions where it does fall short of the mark.

(Kamal, occupational therapist: interview)

Kamal understood the problems with communication to be caused by personal rather than organisational factors. He believed that some members of the nursing the team were disinterested in their work, and that others had become hardened to working in secure units and no longer considered occurrences such as the seclusion of a service user to be unusual. The example provided of the seclusion of a service user not being reported is a strong one as seclusion is rarely used. There were only two seclusion rooms in the service and they were only used as a last resort when the service users' behaviour could not be contained in any other way. Thus, seclusion was an unusual occurrence and should have been fully reported. However, seclusion was instigated, monitored and ended by nurses and doctors and so it was possible that it might not have been considered to be relevant to report to certain members of the MDT such as the occupational therapists in any detail. Thus the reporting nurse rather than being disinterested or case hardened might have been filtering out information that he might not have thought relevant to the members of the MDT in attendance.

The regulation of communication described by some service user participants assumed that nursing staff effectively observed and reported their behaviours and communications. The observations made by nursing staff formed the basis of the nursing reports to the MDT and so influenced decision making. Thus to influence the content of the nursing reports would be to influence MDT decision making. However, communication within the ward and multidisciplinary teams was problematic. Information from nursing staff was distilled into reports and handovers so that it became little more than Chinese whispers. Individual factors affected what was reported and how. Thus the modification of communication by service users with the aim of influencing decision was also problematic with intended messages potentially being lost or distorted due to the idiosyncratic approaches taken to assessment by individual service providers. There was little certainty for service users playing the game. As with Justin (see section 6.3) service users were unable to predict the MDT reaction to their weekly reports, they had to wait until the ward round to discover how much of their good or bad behaviours had been reported. Therefore to play the game

effectively service users had to act as if their behaviours were being observed and faithfully reported as they did not know what had been or would be recorded and then interpreted as significant enough to be included within the nurses' ward round report.

7.3 The avoidance of blame

This section will discuss how service providers (frontline staff and managers) sought to protect themselves from the perceived threat of disciplinary action through the regulation of communication. The avoidance of blame relates to both internal and external influences on the regulation of communication to manage risk status (see Diagram 1) and is discussed further in chapter eight.

Data analysis revealed how staff regulated their communication according to their interaction with formally structured business, particularly in relation to their relationship with senior members of the organisational hierarchy. Perhaps unsurprisingly, data from informal discussions revealed that the regulation of communication by the ward staff within the formal, organisational sphere had been greatly affected by the societal and organisational response to untoward incidents that had occurred in the organisation, including a homicide committed by a service user. Under pressure, the regulation of communication by service providers was overt and thus could be captured during data collection. Nursing staff spoke of their concerns about the threat of the unit being closed, their feelings of guilt regarding incidents that had occurred, and of their fears about being punished for failure.

An example of staff expressing concern about the possibility of losing their jobs was provided by Jean, a health care assistant (HCA). During a period of observation, Jean was observed to sit by the nursing office in the centre of the ward completing an observation chart. The observation charts detail the physical whereabouts of each service user on the ward at regular intervals. Jean called out to another HCA (Doug) who was standing at the entrance to the ward. He was opening the ward door to let a service user out on leave. Jean shouted out to Doug and checked whether he had completed the leave book before he let a patient out of the ward. The leave book is used to record when a service user leaves and returns to the ward, and details such as what they are wearing and where they are going. If a service user absconds, the leave book is used to provide a description of the service user to the police and information

regarding the time they left, and the time that they were expected to return. The researcher asked Jean why she had checked with her colleague regarding whether he had followed the correct routine.

I need to look out for my brothers. If something goes wrong it will come back on all of us!

(Jean HCA: observation)

Jean explained that she was worried that if an incident did occur in the ward then it would affect the all the ward staff and not just the individual involved. It would appear that Jean was acting altruistically, protecting the members of the staff group to which she is aligned. However, the data might also be interpreted as providing an indication that Jean acted in solidarity with her colleagues to manage risk to self. The incidents that she referred to included those in which a member of staff or the public had been hurt or killed and which had serious implications for the service user. Individuals beyond her peer group were also at serious risk of physical and psychological harm if an untoward incident did occur. However, when explaining why there was a need to carefully follow procedures Jean did not express concern for the welfare of service users, or members of the public for whom the potential consequences of an incident are high. This perspective contrasts sharply with concerns regarding service user welfare that were expressed by more senior members of the organisation, and which are discussed later in this section. Instead, Jean focuses on the risk to her colleagues' continued employment. Jean does not appear to be motivated by service user need or public protection. However, by checking that her colleague followed security procedures Jean was protecting the public and training her colleague to do so at the same time, even if this was not her primary motivation.

Jean referred to her colleague as her brother. References to family and the ascribing of familial relationships between colleagues were common amongst African members of the nursing staff. Here Jean referred to a health care assistant (HCA) as her brother, indicating the existence of a close and supportive bond between them, something more than being a colleague or a friend. The priority in a family might be expected to be the family members, rather than external demands. In this case loyalty from colleagues

might be expected to be valued more than organisational rules, laws and outcomes for people outside of the 'family'.

Jean then went on to outline another way that she protected herself against the threat of punishment for error from the organisational hierarchy. Jean described how she avoided reporting problems as she believed that doing so would result in her being blamed and disciplinary action being taken against her. She explained and justified her beliefs by referring to a previous high profile homicide which had occurred in the Trust and the subsequent inquiry, which in her opinion had changed the working atmosphere in the hospital.

Anything can happen, now they can sack you for anything ... now its dog eat dog. Before, at least they [managers] would give you a caution, give you a warning. There was the [serious incident], it changed things, now we are all walking on egg shells. You have to be careful what you say, best to say, "I don't know, I was not there". You could become a scapegoat.

(Jean, health care assistant: observation)

Jean referred to a high profile incident which occurred in the hospital three years ago. She used her knowledge of the previous incident to inform her interpretation of the current work atmosphere and assess the risk to her employment following the recent homicide inquiry report. Jean used the organisational response from the previous incident to inform her expectation of the way that the organisation would manage the current crisis.

Prior to the publication of the homicide inquiry report Jean believed that there would have been a staged approach by managers in response to errors made by ward staff. If she had been found to have failed in her duties, she would be able to expect to receive a reprimand, and be given an opportunity to rectify her behaviour before any formal disciplinary action was taken against her. Now Jean is "walking on egg shells" as she believes that if she did make an error, that she would not be given a second chance. In consequence the stakes had become much higher. Jean perceived that one error could

cause her lose her job; her job security had become fragile so she must tread very carefully not so shatter any security that she has. In the current climate she believed that if she reported problems she would become associated with failure and potentially risk losing her job. Therefore it would appear that Jean's trust in the organisation to support her has been lost, there is no reciprocity and so she must look after herself and her brothers. Jean has chosen to not report incidents or instances of failure, as she does not wish to become "a scapegoat". A scapegoat bears the sins of others, suffering in their place. Thus from Jean's perspective there would seem to be a culture of apportioning blame for error to individuals, in order to deflect blame from others.

The non-reporting of problems breaks the feedback loop which enables the organisation to address problems as they develop and so avert crises. The organisation cannot learn from past failure and so risks repeating errors, where lessons have not been learnt and disseminated. The impact of the regulation of communication and in particular the non-reporting of incidents will be discussed in more detail in chapter 8.

Jean described the way of working on the ward to be "dog eat dog". This phrase would suggest that Jean was conscious that she needed to avoid her colleagues and managers using her as a scapegoat in order to avoid punishment for failure. Thus Jean sought protection and support from her colleagues rather than engaging in formal organisational systems. Therefore it would seem that for front line staff information regarding failure circulated within informal ward systems and social groups rather than official organisational systems.

Jean was a health care assistant, a role which was at the bottom the organisational and nursing hierarchies and so was in a relatively powerless position. To protect herself from censure in a blaming environment, Jean would engage in self-censorship in formal communication systems through the non-reporting of incidents. Jean's communication and risk management practices focussed on the protection of her colleagues and occurred within informal ward communication networks. Thus the direction of expression was away from managerial structures and towards informal networks where she felt safe and protected from censure. Thus, it is likely that

communication of failure from the ward staff to the managerial hierarchy may have become distorted as staff attempted to protect themselves from potential disciplinary action through non-reporting or blaming others. Associated organisational learning was therefore likely to become blocked or distorted as inaccurate information may be used to inform future practice.

During an interview Max, a therapist commented on an incident when a ward manager had been suspended. He understood managerial actions of suspending and removing staff to be part of the organisational response to external criticism.

Fear. I think that the whole [inquiry] thing had happened and there was a sense of sensitivity to bad publicity. My fantasy is that the management felt oh my God if word got out ... we'd never hear the end of it. Personally I think it was an over-reaction ... there might have been another reason for why that decision was made, but as I said my fantasy is that it was the fear of the press finding out and what they would make of it.

(Max, therapist: interview)

Max's viewpoint is consistent with that of Jean, that there was an intolerance of adverse events as the organisation attempted to protect its reputation. The example that Max provides is of a manager being suspended, as he had broken the unit rules. Max does not dispute that the rules were broken. However, he understands the suspension of the manager in terms of a reaction by an organisation sensitised to risk. It was evident from the data that a paradox of disclosure existed within the organisation. In the context of risk assessment and management, service providers were expected to report problems and service users to report symptoms. However, as demonstrated above, the organisational response to the communication of risk was perceived to be largely punitive

The climate of fear also affected higher status service providers, although they responded in a different manner to front line staff. In contrast to Jean, senior members of staff framed their responses in relation to the organisational mission rather than

protecting themselves and their colleagues. For example Marion, a doctor, described experiencing a culture of fear whilst of working in the forensic service following the publication of the inquiry. She included herself in the staff group who were concerned about losing their jobs.

In terms of the clinic, I think there ... was a panic of "Are we going to lose our jobs?" That was the first thing, are they going to close this place? I never thought for a second they would close the clinic because of the financial implications of it ... I think what crossed my mind was more: "is this going to affect the way we practice in a bad way?" ... We couldn't give people leave, we couldn't make decisions that we would have made before. Then there was this culture of blame unfortunately, because it was after [the consultant psychiatrist was dismissed], I think it was [the ward manager] and there was someone else, and there was this culture of, who is going to be next? There was a sense of fear. I think it was hard to work, harder to work during that period, but somehow I managed to detach myself from thinking: 'Is this a temporary transitional period? It is part of this job' That's the way I saw it at the time, its forensics, it is the nature of forensics.

(Marion, doctor: interview)

The report of the inquiry into the homicide committed in the community by a forensic mental health service user who had absconded from the service had recommended the closure of the unit. Marion attributed staff panic to the fear of losing their jobs. Marion outlined the managerial response to the report. She mentioned the change in clinical practice, with clinical decision making being dictated by managerial decisions. She questioned the removal of the power from clinicians to make decisions asserting that the link between improvement in service user behaviour and the provision of greater autonomy would be weakened. The example that Marion provided was that of not being able to give service users leave from the unit, a measure that would have a great impact on the quality of the service users' lives, as well as promoting their rehabilitation, if operated successfully. Through the observation of multi-disciplinary team meetings it was apparent that by giving service users increasing levels of leave from the unit the clinical team tested service users' readiness for discharge. Therefore, through stopping all leave, service user progression towards discharge was potentially halted. Marion described her response to the perceived threat as attempting to make

sense of what was happening and working through potential implications for her clinical work and her employment.

Marion described what she called a culture of blame in which individual clinicians that were connected with the homicide report had been removed from practice in the Trust, one after another. Of the clinicians who were found to be at fault by the inquiry report, only the consultant psychiatrist was officially removed from practice in response to the report. However other clinicians who were named were subsequently disciplined following unconnected incidents and removed from practice, without informing staff who worked with them as to the reasons why they were not coming to work. As a result of the inquiry several clinicians' reputations were damaged, some, irreparably. In the absence of a clear transparent process, staff were fearful that they could be the next person to be disciplined, removed from the unit and possibly lose their jobs. Staff were aware that people had been removed from their posts, but they did not know why it was happening. In consequence managerial activity around the disciplinary process resulted in fear and a protective silencing of failure and problems by members of staff.

Marion described being able to cope with her fears and the pressures of the situation by emotional distancing, suppressing thoughts that caused her to feel fearful. She described initially separating out thoughts about the organisational crisis and then avoiding thinking about the situation. Marion then rationalised what was happening by describing the crisis as being normal for forensic mental health services. Thus Marion would seem to be articulating how she consciously suppressed and her anxieties associated with working within the organisation.

Marion had identified a way of coping with an uncertain situation which she was powerless to change. She had detached herself from the situation, not thinking about what was happening in order to try to manage her anxiety. However through detaching herself from thinking about the crisis she risked not being able to empathise with colleagues and service users who were also emotionally affected by what has happened.

A meta-perspective of the regulation of communication by ward staff as described by Jean and Marion was provided by other participants who reported their observations of

staff behaviour. These research participants described an empathic understanding of ward staff behaviour, and offered explanations for the regulation of communication by ward staff. These descriptions by service user and staff participants provided different perspectives of staff regulation of expression and enabled a broader picture of staff censorship to be constructed.

During a formal interview, one participant described the staff as withdrawing from being active decision makers in order to avoid the possibility of making an error and so protect themselves from potential censure from the managerial hierarchy.

Staff [nursing staff] haven't been so clear about how they're meant to do things, or being prepared to make decisions - the fear of getting it wrong and then being disciplined.

(Max, therapist: interview)

Max also described the staff as lacking the confidence to undertake their clinical roles effectively. According to him staff withdrawal from being active members of the team was compounded by a lack of direction about how they are “meant to do things”. Left without clear guidance, he believed that the staff were unwilling to take decisions, as the risk of making the wrong decision was too great. Through engaging in decision making staff owned the decision and associated risk. Therefore, rather than take the risk of making an error the staff withdrew from actively engaging in decision making, avoiding decision making thereby avoiding risk ownership. The expectations of staff seemed to have broken down. Staff were unsure about what was expected of them and feared managerial censure.

Similarly, during a period of observation, Kevin, a service user participant described nursing staff to be withdrawing from active involvement in their clinical care.

It's just that some staff don't know how to do their jobs. They don't want to get anything wrong, but by doing that they get everything wrong!
(Kevin, service user: observation)

Kevin seemed to validate Max's comments that the ward staff had no clear understanding of their role. Kevin was frustrated with staff who avoided risks. From Kevin's perspective by not actively engaging in managing problems on the ward staff created more problems. As a resident, problems on the ward directly affected Kevin, but he was not in a position where he was able to address them. Staff use of withdrawal to defend against the perceived risk of censure resulted in greater difficulties for the service users as problems were left unaddressed by staff playing it safe. According to this service user, paradoxically through ward based staff managing perceived risk to self through the avoidance of decision making, risks for service users increased. Furthermore, the organisation would also be negatively affected if serious incidents occurred, or service users' progress towards discharge was delayed as a result of problems not being dealt with by frontline staff. Kevin described being frustrated and annoyed with the situation, but acknowledged that staff were not actively engaging with their jobs as they were fearful of the organisational sensitivity, and negative responses to errors or positive risk taking.

Kevin believed that it was only some staff that didn't do their jobs. Similarly, Eugene a charge nurse who worked on the same ward also believed that it was only certain staff that did not actively engage in their work. Eugene referred to nursing staff as *them*, but he himself was a member of nursing team which would indicate that he was differentiating himself from the nurses that didn't know what to do. He attributed staff withdrawal from active engagement to punitive managerial responses to failure.

...They [nursing staff] don't know what to do, they don't want to do anything in case they get into trouble. It makes things worse if someone does something wrong and they get told off, then they move to the other side.

(Eugene, nurse: interview)

Eugene believed that staff who were reprimanded after making an error responded by withdrawing and joining the ward staff who did not wish to do anything in case they got into trouble. Thus, according to him, once reprimanded the staff protected themselves by not taking risks. However, positive risk taking in clinical work is considered to be best practice to promote service user progress towards discharge. The descriptions provided by Max, Kevin and Eugene indicated that they viewed the staff group as being divided between those who withdrew from active engagement in their job and those that were seen to be engaged in their work. Eugene referred to staff metaphorically moving to the other side. One possible interpretation is that the other side he refers to are the nursing staff who have withdrawn from making decisions. Eugene seemed to view those nurses as 'other' to him, in that they occupied a position other to his own. He did not consider himself to be part of that group and therefore maintained that he fulfilled organisational and professional role expectations, and was himself resilient to managerial censure.

One service provider participant described choosing to self-censor in response to a managerial direction. The participant was directed to suppress his voice but he did have the choice whether accept censorship, as he could have approached another member of the organisation, including his union representative. Gareth a Health Care Assistant (HCA) described how he had been a witness to an event (the purchasing of condoms by a patient), that he believed had subsequently contributed to an incident occurring in the unit, and which provided evidence that a particular patient was responsible for that incident. He had tried to communicate the information to a manager. However, the manager advised Gareth to remain silent.

I was there when he bought the condoms. [senior manager] said I shouldn't say anything but I was in the business, I know about patient confidentiality but that only goes so far. He [senior manager] just wanted everything to be kept quiet.

(Gareth, health care assistant: interview)

Gareth was suspicious of the manager's motives for asking him to keep quiet. He based his suspicion on the knowledge regarding confidentiality that he had gained from his experience of working in industry (*the business*). Gareth implied that there was a

hidden agenda, possibly to protect the organisation, which involved keeping things quiet. Gareth did decide to self-censor within the formal organisational context and keep quiet regarding the incident. However he continued to express his views informally, off record. He clearly remained frustrated with the way that the situation was resolved. Gareth did have a choice regarding reporting his concerns and he chose not to report. However for him the outcome was unsatisfactory as it left him feeling frustrated by the situation.

Despite attempts to protect the organisation's reputation through the suppression of voice, information about the service frequently found its way into public arena, via the local press. Nursing office discussion often centred on guessing who had called the press. During an informal nursing team discussion regarding the sensitive nature of a recent serious untoward incident, a clinical manager informed the nursing team that information regarding the incident was already public. A patient had whistle blown to the press about the incident that the service was attempting to contain.

A patient from another ward has already called the press and told them what has happened!

(Aaron, Clinical manager: observation)

In bringing this information to the discussion the manager seemed to be lessening the burden of confidentiality. As the incident was already known, the organisation's reputation had already been put in jeopardy, staff were informally given permission to talk about the incident.

Communication between non-clinical managers and ward staff regarding complaints and disciplinary matters occurred through non face-to-face means such as the sending of emails and letters. The unit managers sent letters to all the staff regarding expected conduct and the introduction of new security measures such as the wearing of belts to attach the ward keys to.

Management send letters to the ward telling them what to do. You never see them! ... They should involve us in making decisions and what to do to solve the problem.

(Carsten, nurse: interview)

Communication by letter was seen by the nursing staff as impersonal and punitive. This form of communication was a one way process, with decisions being made about clinical practice by senior members of the hierarchy who were divorced from care provision without involving the lower grade ward staff who were the direct care providers. Letters needed to be collected and signed for by each member of staff as they entered the building. The letters provided guidance for the introduction of new security measures, and expected staff behaviour, and also outlined the consequences for non-compliance. For example, if a member of staff reported for duty without a belt they would be sent home and would not be paid for that shift of duty. Thus, in response to a serious incident there has been an increase in the attempted regulation of staff conduct and communication between ward staff and high ranking unit managers had become strained and largely unidirectional.

However ward staff also communicated with unit managers by letter. Anonymous letters were sent by members of ward staff to managers which raised issues regarding safe practice. The letters also accused the management team of racism and nepotism. The staff sent the letters to the chief executive of the Trust of which the unit was a part, and the local press as well as to the unit management team. Similar to the service users who raised complaints through the advocacy service (see section 7.3), by writing anonymously staff members were able to have their voice heard by senior members of the organisational hierarchy whilst limiting perceived risks to self. The veracity of the accusations made in the letters was difficult to ascertain and so the letters could have been discredited and ignored. However, the copying of the letter to the press and Chief executive drew attention to the unit and prevented the letters from being dismissed.

Overall, although there was an apparent absence of guidance for ward staff to make clinical decisions, greater regulation of staff conduct and security had been imposed by senior managers. Communication between the senior management and the ward staff had largely broken down. Managers issued formal notice of changes to working

practices which staff felt able to challenge only through anonymous letters and the involvement of individuals and organisations external to the unit and the Trust. Ironically, by acting unilaterally to protect the organisation's reputation by imposing new unit rules the senior management had prompted the ward staff to make public the unit's problems.

Communication between ward staff and senior managers was also observed to occur through non-cooperation. One ward manager, Eric, described how he had rejected an offer of support from high ranking unit managers. In this way he expressed his dissatisfaction with the way in which decisions about his ward had been made in isolation by senior managers within the service and to challenge organisational systems. During an interview, the researcher asked Eric how he had been supported by his colleagues when the ward he was managing had been closed.

People ring up and ask me if I am OK. It's just a ward, it's the staff and patients I worry about. The [senior manager] asked me how I could be supported. [I declined] if they wanted to support me they could have involved me in the whole process

(Eric, ward manager: interview)

Eric had not been included in discussions by senior managers regarding the closure of the ward. He had been informed of the ward closure in a unit meeting; at the same time as all the ward staff. In stating that "it is just a ward" Eric minimised his need for support, placing himself in a less vulnerable position to the ward staff and service users. He grouped together the ward staff and the patients, indicating that they faced similar risks from ward closure. Staff and service users were to be moved to other wards, or hospitals with little choice as to where they might be sent.

Eric rejected the senior managers' offer of support. He had been previously excluded by the managers and not treated according to his position in the organisational hierarchy. He then rejected an offer of support by the senior managers, and cut the caring, supportive agenda of communication with them. In so doing, Eric sent a

message that it was too late for him to be involved at this point; he should have been involved when the decision was being made.

In a similar manner to the staff writing letters anonymously, managers were found to protect staff by maintaining anonymity when raising areas of concern. During a ward business meeting, a consultant psychiatrist, who was a clinical manager and a senior member of the MDT, took a different approach from those described above to addressing problems with staff behaviour. The ward business meeting was a forum for the discussion of matters of ward management and was attended by the ward staff, mainly nurses, doctors and occupational therapists.

... There have been many instances of keys not being worn belts. I am naming no names but this is something that needs reiterating.

(Damian, doctor: observation)

Damian avoided directly confronting the ward staff by self censoring and not naming individuals. The ward manager, who was responsible for managing the nursing staff was present at the meeting. If names had been mentioned the ward manager would have been obliged to reprimand the staff who had breached ward security rules. Therefore, Damian chose not to “tell tales” and thereby avoided evoking a formal managerial response. Damian also avoided any injudicious or unverifiable accusations being made. However he had raised general awareness of the need to follow security procedure the issue and staff were also left with the awareness that they might be reprimanded in the future. In this way he had been able to safely communicate his concerns regarding security whilst avoiding individual blaming and potential disruption.

Communication between members of the staff team regarding changes taking place within the service also occurred informally and outside of the control of the unit managers. Thus an underground system of communication between staff existed where views that individuals believed would be unacceptable to the unit managers could be expressed. Derek, a manager expressed his concerns regarding the impact of staff communication which he was unable to monitor and control.

Most of the things that were are causing enormous anxiety in the service, is just petty gossip, and rumours this person said this ... I hear that [rumour] there will be further cuts...

(Derek, clinical manager: interview)

Derek took a pro-organisational position from which he viewed gossip as subversive rather than an outlet for staff tensions. He dismissed unofficial communications by staff, and by labelling them as petty gossip and rumours, he indicated that he considered them to be malicious and unreliable. He did not see any value or reasons for the communications. For Derek, underground communication by staff made his job more difficult, and was detrimental to the service. However, the existence of rumour and gossip could be interpreted as staff creating an outlet to safely express authentic feelings and anxieties about the changes that were taking place within the service. Furthermore through gossip ward staff concerns were being raised anonymously, as no one cited the source of the information, and managers could not act on unsubstantiated rumours, and so issues were safely communicated to unit managers.

Another way that communication by front line service providers to high ranking managers also took place anonymously was via union representatives. Max, a therapist commented on the way that Derek and other managers reacted to anonymous communication from ward staff through their union representatives.

What [Derek] and [a manager] did was try to arrange to meet individually with the union reps and basically give them an ear bashing [about raising concerns], saying this isn't the way you go about things, blah, blah, blah there are procedures, and [name], the union rep, said Well I think this is interesting that members don't feel safe enough to raise things directly through the line management. Because they're afraid that they're going to be penalised if they do. It says something about the way the management is perceived here.

(Max, therapist: interview)

Max believed that the management team had attempted to prevent union representatives from communicating about issues that had been raised by the union members working within the service. Like the service users discussed in the last chapter, staff believed that they were in a vulnerable position and needed a person external to the organisation to advocate on their behalf. However, managers challenged the legitimacy of the provision of advocacy for staff whilst accepting it for service users as long as approved channels were used. They believed that staff should follow established internal procedures for communicating with managers.

A staff request for an advocacy service to represent them was highlighted by Kate, a service user advocate during an interview. Karen spent time on each of the wards speaking to service users and staff. During one of these visits a member of staff requested that the advocacy service be extended to include staff, thus indicating that staff did not feel heard by senior managers, or able to voice their concerns that they had.

Kate: Quite a lot of staff say, "Why don't you advocate for the staff?"

Researcher: Really?

Kate: Yeah, lots of people have said. Why don't the staff have an advocacy service. And we're saying, but you know, you've got the opportunity of joining a trade union. You know, I mean, you've got all your colleagues around you. You're in a position of power, it's very strange!

Kate dismissed the staff request, as in her view compared to service users they were in a powerful position and so did not need an advocacy service to provide them with a voice. As with Derek, Karen believed that staff already had a voice within the service and so did not provide them with support, whilst Max felt that managers actively silenced the staff voice. Ironically, service users were provided with a mechanism for voice whereas staff were not, and so users were possibly more able to influence the organisation than frontline staff.

During another interview, a year later Derek expressed a different view of communication between ward staff and unit managers, which indicated his belief that open systems of communication within the service had begun to be built.

I think all that understanding is there now, within the service. I suspect that's why generally things are stable, people are happy, and the majority of senior staff, managers, I must admit, we have not seen things in that perspective before. Before [manager] left we thought, "Let's take a step back and really look at these, how do we really minimize all these problems?" It's not to feel frustrated or be angry, that oh, these people are writing these letters. We need an open door policy for people to feel more comfortable, let them feel that we are approachable, what is it that is making people so reckless and secretive?

(Derek, clinical manager: interview)

Derek described the unit managers as having gone through a process of reflection regarding anonymous staff communications. The reflection had taken place as part of the review of the service in response to the recommendations of the homicide inquiry report. Rather than dismiss the anonymous letters that had been causing great frustration they had attempted to make sense of them. The anonymous letters and gossip are reframed from malicious attacks on the organisation to staff making attempts to communicate with management. The managers responded by encouraging staff to communicate with them directly. Thus from Derek's perspective there had been a move towards recognising organisational barriers to communication and away from viewing individuals as the cause of problems within the organisation.

7.4 Silencing challenges to the social order

This section critically examines how individuals modified communication in response to pressure exerted by peers and social groups to silence reports of failure in order to protect the reputation of the organisation, and prevent disruption to the service. The

interaction between informal and formal systems of communication will be explored in particular around the non-reporting of error to formal organisational systems.

An example of formal communication systems being affected by informal social networks was provided by Barbara, a HCA during a period of observation. Barbara was working as the shift security nurse. This role was allocated to one nurse for each shift of duty. The security nurse monitored the safety of the ward environment, including the use of restricted access items by service users. These are items that the service user is not allowed keep in their possession such as razors, but which their clinical team have agreed that they can have access to in order to fulfil their activities of daily living. Security nurses also check the ward environment and ensure that all ward facilities are in good working order. The security nurse is expected to report any problems with security to the nurse in charge so that action can be taken to manage any associated risks. During an informal discussion Barbara explained that she had chosen not to report a security issue to the nurse in charge as she had had bad experiences with a peer after speaking up in relation to an earlier breach of ward rules.

Barbara (HCA): I wonder if [Ronald] (nurse) knows [he hasn't] got [his] mobile? I saw two patients fighting over something, it was his mobile. He said he thought he had dropped it during the incident.

Researcher: You should let him know about it. It could be quite serious if [Ronald] told [the ward manager] he has lost his mobile on the ward

Babara (HCA): No I am not doing that anymore. I spoke to [Jean] about putting seven and a half hours on [her] time sheet. Now it's [Barbara] know everything! So now I am going to keep my mouth shut! [Jean] was very angry with me, I had to get on my knees and beg her to forgive me. We normally laugh and joke. All I said was not that lock, the other one and she was saying that I thought I knew it all.

The mobile phone was considered to be a contraband item and therefore, the security nurse Barbara would be expected to let the nurse in charge know that security had been breached. Service users and staff were not allowed to have mobile phones in

their possession whilst on the ward, and could only use them outside in the hospital grounds. Not only had a mobile phone been in the possession of a patient, a nurse, Ronald, had also been carrying a phone whilst on the ward which was against the ward rules. Potentially there were serious consequences for Ronald. If the ward manager had been made aware of the breach of security, Ronald might have been subject to disciplinary procedures. Moreover, the patient might have been able to access Ronald's personal information on the mobile, including phone numbers and pictures. Thus there was a potential risk to Ronald from the service user, as well as a risk of the service user using the telephone to help him to abscond from the unit.

The researcher was very aware of the potential risks and with my question attempted to inadvertently prompt Barbara to warn Ronald. Thus the researcher had made a transition from the role of observer to one of risk manager. Like Jean the researcher was seeking to protect the ward staff with whom she had built strong working relationships.

Barbara explained why she had not reported the security breach by describing an altercation that had previously taken place between herself and Jean when she had reminded Jean of organisational rules. Barbara had reminded Jean that she couldn't claim seven and a half hours agency work on her time sheet. When working a second shift in the working day, staff could not claim for the full seven and a half hours of the shift as there was a one and a half hour hand over time which overlaps between the two shifts. To claim for seven and a half hour shift, rather than the additional six hours that she worked would be fraudulent and so Jean would risk losing her job if managers became aware that she had been paid twice for working the one and a half hour hand over period. By reminding Jean that she should only claim for six hours Barbara was protecting Jean (looking out for her sister) as well as acting in her work role and reinforcing the organisational rules. However, in response to Barbara's intervention Jean withdrew her friendship. Barbara had to beg Jean before she reinstated their friendship. Later, when Barbara reminded Jean about a security issue concerning locks Jean responded with disapproval, and mocked Barbara for undertaking her role as a security nurse. It would seem that Jean was defending herself against a perceived threat to her job. If the security breach was not reported she would not be associated with failure. Jean was acting out her description of "dog eat dog" (see section 7.3) by preserving her informal network and asserting herself within the informal hierarchy of

the ward in order to protect herself in a situation where she believed that reported security lapses will be dealt with punitively. In response to the risk of future bullying and the loss of a relationship that she values, Barbara chose to self-censor and not raise security issues. Thus, important security issues were silenced and the organisation was unable to respond to them. Barbara had been brought in line with the ward informal network and continued to be an insider. One of the tacit emergent rules of group membership seemed to have been clearly articulated; that errors made by group members are not reported to the managerial hierarchy. From Jean's description it would seem that she perceived the threat to the ward group from the organisation has become greater since the publication of the homicide inquiry report (see section 7.3). The group therefore needed to protect itself and did so by regulating communication by its members with formal organisational systems. Thus the separation between staff at the lower and higher parts of the organisational hierarchy seemed to have become more distinct. Formal systems of risk management are dependent on intelligence and information gathering. The blocking of information being communicated from day to day clinical activities to decision making forums hinders risk management and leaves the organisation at threat of further incidents occurring.

7.4.1 Informal group pressure to regulate communication

The regulation of communication by nursing staff was also described by research participants in the context of their relationships with groups of staff defined by group ethnic origin. For example self-censorship was employed by individuals to protect against social risks of being ostracised. Self-censorship in response to pressure from self-forming groups is discussed within in relation to the emergent theory of the regulation of communication in order to manage risk status in chapter eight. Service providers also feared being accused of racism as this could result in formal disciplinary action as well as condemnation by colleagues. Problems with communication, team working and care provision relating to issues of race were often silenced, justified by the threat to others and/or couched in terms which the individual felt would prevent them from being labelled as racist.

During data collection it became apparent that ward staff were suspicious about the researcher's observation of ward activities. During an informal discussion, George, a

nurse voiced his concerns regarding informal staff ward groups. George described staff forming groups according to commonalities of age, experience and culture. He described staff as finding support through being members of informal groups. However, he also felt that there was a more harmful dimension to staff groups, which could become exclusive and defensive.

Some staff on the ward only want to work with older staff who do the same thing. They will never tell you what is happening, and you [the researcher] not having a key makes it easy for them. They know when you are coming. They will see two people from [the same University] talking together. They won't want to talk to me now. They wanted to pin a drug error on me....there is a Ghanaian clique, they all stick together but when something goes wrong they are quick to desert each other!

(George, nurse: observation)

Whilst the researcher was in the service user lounge observing the ward activities George came and sat next to her. He proceeded to describe some of the problems that he had experienced whilst working on the ward. He described himself as an outsider to the self-forming ward groups as he did not share the common attributes of the group members. Unlike the other nurses he had not trained at the university which was local to the Trust. In consequence, the other nurses that he worked with on the ward had established relationships with one another whilst undertaking their nurse training. George had trained at the university where the researcher worked, and he often approached the researcher and asked for advice regarding nursing practice, particularly when he was in disagreement with other members of the nursing team. However, on this occasion, he expressed his concern that the other nurses would believe that something sinister was happening as two nurses from the same university were sitting and talking together. This would suggest that the other ward nurses had previously ostracised him for talking to me. George seemed defiant, but was still conscious that he did not wish to be subject to any retribution by the group, such as being blamed for errors. He kept the conversation short, and did not provide any further detail about the groups he described, such as the names of the group members. He seemed anxious and, whilst keen to regulate his communication, and not be seen to talk to an outsider, he was also keen to reach out for support from a person with whom

he had something in common. George seemed to be balancing his need to voice his concerns and seek support and to not draw a negative response from the established informal group.

There would seem to be resonances with Jean's comments regarding not wanting to be associated with failure nor risk being made the scapegoat. George describes his perception that an informal ward group will try to use threat of association with failure as means of censure. Furthermore it would seem that George was concerned about being ostracised by the ward group for reporting failure. Thus George describes inducement by informal ward groups to modify his communication with formal organisational systems through the censorship of reports of failure to comply with Trust policy or professional standards.

George also described individuals aligning themselves to groups according to their ethnic identity. The example he gives is of a Ghanaian clique. George was from Zimbabwe, and so was ethnically an outsider to the group. He described the group in negative terms, as a clique, from which he and others are excluded. He could not gain entry to the group as membership was based on ethnic origin and so he had to remain as an outsider. However, it is unclear as to whether George wished to or had attempted to join the group. He stated that the group had attempted to have him blamed for a drug error as he did not follow its rules for concealing errors and protecting group members from managerial censure. Therefore the group not only had rules for its members but also for individuals that work alongside the group on the ward. This would indicate that from George's perspective that the group was powerful and held influence over members of the ward nursing team.

From George's description of the Ghanaian staff group it would appear that similar to Jean, ward staff had an expectation that support would come from one's brothers. However George described these bonds as being weak, with group members not supporting one another when there was a crisis. From George's description the group members' bonds were weak because when under threat group loyalty was disregarded with individuals protecting themselves rather than the group. George was contemptuous of the group, describing the power that it gained from members

providing mutual support as being only superficial. During the conversation a member of the domestic staff walked into the room. George and the domestic worker greeted one another effusively, George then turned his attention back to the researcher and said *this is my sister she is my fellow countryman, from Zimbabwe*. Thus George also sought support from individuals with whom he has commonalities of ethnicity or in relation to education.

Another participant, Eric, provided a different perspective on the clique that George described. Eric expressed concern regarding how a staff group was behaving counter to his expectations of people from their cultural background.

...The Afro Caribbean culture is a culture of interaction. Black people talk too much among themselves, right! and you would you have expected them to bring in that talking into their job, but on the contrary when they come in here they are like they become recluse ... I was really shocked because what I saw are people who forgot who they are or what they are and the natural skills they have. Rather, they take this offish approach you know which, its escalatory, it escalates the situation. Because I know, in the black community for example if somebody 'Oh please get off that' rather than taking it, the what I say [call], I don't care position and then being confrontational they'll go [say] "oh come on why are you behaving that?", no[t] "hey I don't expect you to behave like that you should know better"

(Eric, manager: interview)

Eric, who was African, identified the group broadly as Afro-Caribbean rather than in terms of one particular nationality. He drew on his understanding of Afro-Caribbean culture to explain why he found the behaviour of the staff to be unusual, and unexpected. Eric expected the group to be voluble; he believed that talking was natural for Afro-Caribbean people; it was part of their culture. However, he noticed that the staff group was not talking, and not using their communication skills to work with the service users. The ward nursing team were failing to address incidents that occurred in the ward. The group was not confronting problems; instead the staff were withdrawing their communication with service users and providers. Thus Eric, like George described the ward staff as becoming an insular group that was defined by their ethnicity.

However, rather than focussing on disfunctionality, Eric was concerned about the welfare of the group members. He understood their behaviour to be caused by the unit environment rather than their culture or individual personality. Therefore Eric perceived that the formation of staff groups and the regulation communication was influenced by the ecology of the unit.

A service user perspective on the staff group described by Eric was provided during an informal discussion with Darren, a service user. The researcher mentioned to Darren her intention to spend time observing the ward where the staff group worked. Darren responded that he felt it would be good if the researcher went there, so that she would witness how the ward staff interacted with the service users. Darren was keen for the researcher to observe ward activities so that poor practice would be exposed.

Darren: *Yeah you should go to [ward name] they are draconian, they are inappropriate with the patients.*

Researcher: *How are they inappropriate?*

Darren: *I don't know, inappropriate, confrontational. They all fit in with each other, they come in [new staff] and fit in.*

Darren's description reinforced the notion that a clique existed on the ward which reinforced inappropriate styles of communication. Like Eric, he described the nursing staff as confrontational. He attributed staff behaviour to the ward or staff group rather than individuals. New staff who went to work on the ward conformed with the group and did not challenge poor practice. Darren did not consider the group to form along ethnic lines, rather that the staff became socialised to a pre-existing culture that was particular to that ward. In such a closed culture it would be expected that it would be difficult for service users to complain about poor practice. Therefore Darren saw an opportunity for the research to provide a voice for service users and highlight the problems they faced.

An explanation for the nurses' confrontational communication style is provided by Marion. Her understanding of the nurses being withdrawn and cliquey is of the nurses protecting themselves from the organisation.

Yes, very cliquey, because they had been there - they were telling me that they had been there for a long time, and I think there was this culture in [ward name] that not everyone wanted to work in [ward name] in the old days, no one wanted to I think, that was the impression I had. So the people [nurses] that had been sent there, it was almost like either a punishment, or they just they felt they weren't good enough, so they had to be sent to that place. So it felt like they were always protecting themselves against the others, because of that.

(Marion, doctor: interview)

Marion described the cliques as forming for self protection and support, rather than along ethnic lines. Thus she understood the confrontational communication as a form of defence against the others. It was unclear who the others were. However, it might be interpreted that the others were the managerial hierarchy, those that sent the nurses to the ward for punishment. From Marion's description the nurses had been marginalised by the service, with the ward essentially becoming a ghetto for poorly performing or bad nurses. Rejected by the service, the ward nursing group had become inward facing and defensive.

During an informal conversation, a manager (Sarah) mentioned an untoward incident that had happened on a ward outside the unit. She perceived that culturally defined ward based staff groups had adversely affected communication between staff which had contributed to the incident occurring.

I shouldn't really say this, it's cultural. On [ward name] there were four staff talking in Mauritian. The two others didn't know what was going on!

(Sarah, manager: observation)

Sarah began by saying that she “shouldn’t really be saying this as it is cultural”. Sarah’s comment indicated a perception that it was dangerous to openly discuss issues relating to ethnicity, even in relation to safe ways of working. She then explained that a serious incident occurred in another service which was partly caused by a handover between nursing shifts being given in a non-English language. This meant that two of the nursing staff were unaware of potential risks posed by service users to themselves and others. On a shift of duty there would have been six members of nursing staff. In this case four were Mauritian, and two were not. The Mauritian members of staff handed over information regarding the service users’ presentation during a previous shift in their language, French. This meant that the other non-Mauritian members of staff were put at risk as they did not understand the handover. One member of staff was subsequently killed by a service user. The incident was the subject of an internal and external inquiry and recommendations made for practice. However, Sarah was uncomfortable discussing the issues for practice as they related to staff ethnicity.

Sarah’s comments were echoed by Jack a health care assistant. He described colleagues speaking in languages other than English, and being hesitant to complain for fear of being labelled racist. However, Jack described instances when he had been able to speak out about problems with communication in relation to working with African nurses. He justified speaking out in terms of protecting service users and his colleagues. Thus, Jack described regulating his communication according to the potential risk of being labelled as racist against his sense of justice and the need to care for those that he sees as vulnerable.

Where to start this without being accused of being racist? ... We’ve got a couple of Mauritian patients, sorry staff members. And all the rest are African. . . They’re talking in African deliberately. And the only reason people are talking in African on a ward is to make sure that you don’t understand what they’re talking about and its all sorts of things going on amongst them, within their own sort of clique. I know, whatever you says gonna sound racist . . . I’ve watched people leave because they were so isolated on the ward where everybody else was talking in African. I’ve heard patients discussed in African among other staff members, and by doing that they’re quite aware that you can’t understand what they’re saying about that patient. (Jack, health care assistant: interview)

Jack described his perception of African nurses using a non-English language to regulate communication and to designate their membership of an exclusive group. Jack perceived the group as malevolent, deliberately excluding non-African nurses. He described a reluctance to talk about the situation as he feels that he will be labelled as racist, even though nurses were not allowed to speak to one another in a non-English language whilst in a clinical area. Thus the threat of being labelled as racist could strongly influence how participants, particularly those whose ethnicity was white British to regulate their communication.

However Jack also provided an example of when he had spoken out about racism when linked to working practices, which he believed were unfair.

I had to write sort of letters and I didn't actually say it was racism. I can't remember the wording. I spent a long time wording the letter so it didn't sound too bad. But as far as I was concerned they had a choice either they would do something about it or I would and then it would make the papers.

(Jack, HCA: interview)

Jack protected himself by carefully wording his letter and in particular not labelling the issue he was complaining about as racism by black African to white British staff. Thus Jack modified his communication in order to achieve the result that he wanted. However, he failed to resolve his main complaint, that of racism. As with staff sending anonymous letters, as discussed above, Jack strengthened his position with the threat of going to the press and making his concerns public. In so doing Jack assured himself that he was not in a powerless position in relation to the unit managers; he had the power to go to the press and damage the organisation's reputation. Jack's approach of threatening to involve the press also reflected that of service users openly threatening to go to the press if their complaints were not heard (see section 6.3.2). In both cases power to speak and to make oneself heard was obtained through the high risk strategy of threatening to whistle blow and damage the reputation of the organisation.

7.4.2 Advice for the researcher as an outsider to self-censor

The researcher became increasingly aware of her own self-censorship during data collection as she responded to both unspoken cues to regulate expression and also direct advice to self-censor. Examples of the direct advice the researcher was given to self-censor are discussed below. Often individuals communicated a need for the researcher to moderate her communication through facial expressions of disapproval or discomfort, for example when she had acted in the role as a senior nurse rather than a researcher and raised issues of poor practice. (The roles of the researcher will be discussed in sections 4.9 and 5.2)

Prior to leaving a ward that the researcher had been observing for several weeks and commencing observation on another ward in the unit, Jonathan, a nurse, called the researcher to one side and advised her how she should behave on the ward that she was to observe next. Jonathan advised the researcher to self-censor, to keep her mouth shut as he was aware of a previous incident where the ward manager he was referring to had become verbally aggressive towards a female member of staff who had been assertive during a discussion with him.

Be careful, keep your mouth shut on [ward name] [the ward manager] has a problem with women.... He had been rude to one of the secretaries. In the car with [nurse] he was reading a book about how women get what they want.

(Jonathan, nurse: observation)

Jonathan expressed concern for the researcher's welfare. He felt that there was a potential threat from the ward manager towards her if she was outspoken, and so advised the researcher to say nothing. It was unclear as to whether he felt that the nature of the threat was physical, verbal or to continued access to the unit for data collection. Jonathan felt that the researcher was at risk due to her gender and the likelihood that she would act outside of a traditional female gender role. Thus, in this instance, the regulation of communication was linked to gender stereotypes.

The researcher was also advised to self-censor by a member of the multidisciplinary team who felt that comments that she had made were affecting ward team dynamics. Following a formal interview, once the recording equipment had been turned off, Kirsten an occupational therapist (OT), offered the researcher some advice in relation to what to say during ward community meetings on a specific ward. The researcher had been regularly attending and observing ward community meetings. At one meeting, there had been a request by a service user for a ward pet. Following a lengthy discussion the service users decided that they did not wish to have the full responsibility of looking after a ward pet but would prefer to have a PAT (Pets As Therapy) dog visit the ward instead. The researcher had missed the next meeting and at the following meeting PAT dogs were not on the agenda. At the end of the meeting when the chair asked if there was any other business the researcher inquired whether there had been any progress with arranging for the PAT dogs to come onto the ward. The OT at the meeting replied that they were waiting for the unit manager to give their permission. None of the service users made any comments. It was this question that had concerned Kirsten.

Before you go I need to give you some advice. You need to be careful what you say in the community meeting, there are undercurrents. [OT name] face when you mentioned PAT dogs, we had passed it over to [ward manager] and he has to ask [unit manager]. [Unit manager] hates PAT dogs. I don't know how [ward name] got PAT dogs! There's politics, [WM] doesn't rate the OT department, and undermines them.

(Kirsten, occupational therapist: observation)

Kirsten outlined the dynamics of a ward team, as she had experienced them. She described the ward manager as being dismissive of occupational therapy, and the service manager as not wanting to have PAT dogs in the service. Kirsten saw a division between managers (both clinical and non-clinical) and the occupational therapists, with respect to this particular issue. According to her, by asking questions in the ward community meeting regarding an apparently innocuous subject, the researcher had enflamed an ongoing conflict between different disciplines. By naively enquiring about what had happened regarding a decision made at a previous community meeting, the researcher had unintentionally threatened the social order of

that particular ward. Kirsten alerted the researcher to the situation and encouraged her to regulate her communication. In so doing Kirsten attempted to maintain the status quo and reduce the risk of conflict between the OTs and the service managers, shutting down a perceived challenge to the social order. Conformity was also promoted through encouraging the researcher to self-censor.

7.5 Medical dominance and multidisciplinary team power relationships.

This section explores the regulation of communication within the multidisciplinary team in the context of professional power relationships, participants' perceptions of medical dominance and the organisational response to the publication of the homicide inquiry.

Staff described regulating their communication in multi-disciplinary team (MDT) meetings in response to perceived power relationships between team members. In particular, MDT members described choosing not to express their opinions, and to acquiesce to the dominant view within the team, often that of the consultant psychiatrist. Participants described being frustrated with being unable to assert their opinions or openly challenge the team view. One participant, Joy, a social worker, described how she saw other members of the MDT treating the consultant psychiatrist as the leader and main decision maker.

I think you do get the issue where people see the consultant as the leader of the team and as having the final say and as being in charge and people on the rest of the team think often, "We'll just defer to that". So whatever the consultant says, everyone else will just kind of agree.

(Joy, social worker: interview)

Joy described the team functioning with the assumption that the consultant was in charge as an issue, thus indicating that she considered medical dominance within the MDT to be problematic. She then provided an example of how members of the MDT regulated their communication in response to experiencing a conflict of interest regarding service users requesting a change of consultant. Service users were often described by staff participants as making requests to change their consultants in an

attempt to get onto the case load of a consultant who was believed by the service user to discharge their patients more often. Joy described how it would be difficult for MDT members to express their support for a service user request to change consultants.

Same team, different consultants. There are differences in the way that consultants treat people. They are working differently, one will give a patient leave, another not. It is OK if there is one consultant on the ward. There have been some problems on the ward recently, it depends on who the two consultants are. Some patients want to move between consultants. It is difficult for health care professionals when they share that point of view. I am not talking about consultants being careless but there is more chance of the patients realising their potential... It doesn't matter how well we lead that if we hit that barrier, it's the resistance of the consultant ... Sometimes consultants take it personally, sometimes they are quite relieved

(Joy, Social Worker: interview)

Joy began by highlighting the power of the consultant psychiatrist. The multi-disciplinary teams were ward based, so at each ward based MDT meeting the team remained the same, but the consultant changed, as each consultant was the Responsible Medical Officer (RMO) for a different group of service users on the ward. Joy made the point that despite the team remaining the same, the decisions for the RMO patient groups were not equitable, thus illustrating the decision making power of the consultant psychiatrist within the team. Each consultant psychiatrist interpreted the clinical rules differently when applying them to individual cases, and so there was an apparent inequity when different consultants worked with the same patient group. At the same time the power of the consultant acted to mask such inconsistencies.

Joy categorised consultant psychiatrists according to whether she saw them as being restrictive or flexible in their approach to decision making. She valued the more flexible consultant psychiatrists who she saw as enabling service users to achieve their potential. She saw other restrictive consultants as barriers to therapeutic progress. She justified users' attempts to change consultant on the grounds that some consultants became insurmountable barriers to therapeutic progress both for the MDT and the

service user. In response, both users and members of the MDT circumvented the system through the service user requesting to change consultants. However, it was difficult for members of the MDT to request a change of consultant on behalf of a service user or to openly encourage a service user to request to change their consultant. There was a risk that such a request would be interpreted by the consultant as an open criticism of their professional practice. It may also be problematic for service users to request a change of consultant as the consultant might be offended by the request, taking it personally. If the request was not agreed then the service user might be left with a consultant who has taken offence at them wanting to leave their care.

However, Joy also described some consultants as being relieved when a patient requested to change their consultant. This would suggest that consultants also do not feel able to ask for a patient to be moved to another consultant. It would also imply that, although consultants have the most powerful position in the team, which influenced the regulation of communication by other members of the MDT, they themselves feel unable to admit defeat as this might erode their status and credibility as a psychiatrist.

Obviously I can't say to the patient as well, I wouldn't say to the patient, "Well it wasn't me it was them", because then that's just splitting the team, and that I find difficult sometimes. Because, or especially when I'm having to say something to the patient that I don't agree with. But obviously the team does [agree] and those sort of things I think can be really difficult.

(Joy, social worker: interview)

During a formal interview Karen, an Occupational Therapist (OT) also raised concerns regarding multi-disciplinary team working, communication and risk management. She depicted disorganised communication, and defensive functioning within the team.

I feel like these sort of decisions [risk management] are made just randomly according to who's there and how strongly they state their case. And I think it's

partially to do with the communication side of things and people not having full discussions and its partially because of if one person raises a concern and then something does happen the consultant is concerned that: 'well, the concern was raised, why didn't you do something about it?' That's what their concern is, even though one person may have raised it and everyone else may have said: 'No this isn't ... We don't need to act on this risk'.

(Karen, occupational therapist: interview)

In Karen's view, decisions were not being made consistently but according to how assertively individual clinicians put across their case. Therefore decisions were not being made according to the information available, but how that information was conveyed. Communications were disorganised, but despite this self-expression continued to be regulated. In the decision making process, concerns expressed regarding risk were described to trump all others, including the need to promote service user autonomy. For Karen the focus on risk was heightened by concerns that the consultant would not support team members if an untoward incident occurred. If an incident did occur, and it was found that a member of the team has not acted upon concerns of risk have been upon then they could be found to be at fault and would not be supported by the consultant. Thus, the consultant bestowed risk ownership on the members of staff who expressed concern, thereby incentivising them to keep quiet. It is unclear whether this cue to silence was deliberate or not. Team members must regulate communications and decision making according to fear of the potential occurrence future incidents and the apportioning of blame. Once risk was articulated the clinician and the team needed to demonstrate that they had managed it. Thus risk might be evoked by an individual to strongly state their case, but might be silenced as the communication of risk brought with it responsibilities and possibly blame.

Karen provided an example of how the disorganised and risk sensitive team communication negatively affected team functioning and relationships with service users.

I feel like the patients are getting stuck ... It's too complicated to go into really but the patient and the consultant sort of, didn't really get on. There was a sort of

split, they had personality disorder, which tends to split teams. And the team were quite split about whether this person should get ground leave or not and it just all ended up going backwards because of the series of incidents and the patient becoming more frustrated and I could understand completely why the patient was becoming more frustrated because they felt as a team we were contradicting ourselves and don't feel like we were making very good decisions ... Therefore the risk if he did get ground leave would have strongly become higher because he was so frustrated. Partially due to ... the decisions that we were making.

(Karen, occupational therapist: interview)

Communication by members of the MDT with service users reflected the disorganised systems of communication, the associated defensive regulation of self-expression and the unspoken frustration of team members. Karen described one service user as becoming increasingly frustrated with the team decision making. She linked the service users increased frustration with the team decision making to an increased risk of him absconding. Karen links the problems with team functioning and communication which she identifies with an escalation of risk. Thus, according to her the team had unintentionally created a self-fulfilling prophecy. As a result of the team restricting the service user's freedoms, the service user became increasingly frustrated and more likely to react in a way which risk management was designed to prevent such as absconding or becoming violent. In Karen's view, the MDT as well as the patients were getting stuck as the patients could not move on, and the staff were unable to reverse decisions that they had made which limited the service user's autonomy.

It felt like every time to have a discussion that we would end up one step further back because we had discussed the risks and one person would put forward an idea of risk that maybe he shouldn't even be at this stage and it was really frustrating.

(Karen, occupational therapist: interview)

From Karen's perspective, service users and staff had become trapped in a spiral of the risk communication, restriction and incidents.

Similarly some clinicians considered themselves unable to challenge the restrictions imposed on service users by the hospital managers. They felt that their power to make clinical decisions had been over-ridden. The inquiry into the homicide committed by a user of the forensic service found that clinicians had failed to manage risk effectively. In consequence it was difficult to challenge the restrictions imposed by hospital administration or to manage risks associated with service user behaviour on the basis of clinical expertise. Clinicians believed that the restrictions could be challenged on legal and ethical (human rights) grounds by the service users. However they felt unable to directly ask service users to challenge the system.

For Karen the issues around communication relate to who has the ear of the consultant. From her perspective, one way to influence decision making was to raise concerns regarding risk, as this issue had become highly influential as following the publication of the homicide inquiry report she depicts a psychiatrist as becoming more sensitive to issues of risk and defensive in his practice:

if one person raises a concern and then something does happen the consultant is concerned that: 'Well, the concern was raised, why didn't you do something about it?'

(Karen, occupational therapist: interview)

Karen described concerns voiced regarding risk being attended to by the consultant in preference to views expressed that attempt to allay fears, and promote giving service users greater freedom. It could be interpreted that the consultant was being cautious when making decisions in order to defend against the risk of another serious untoward incident occurring (SUI). Alternatively the consultant might be practicing defensively, putting measures in place to protect himself and the MDT from blame if another incident did occur. In Karen's view risk had come to dominate team decision making,

and over rode other clinical factors. According to her, the clinical team focussed upon risk avoidance rather than therapy.

The power imbalance between the doctors and other members of the MDT was highlighted by Enid a health care assistant (HCA). During an informal conversation regarding a serious untoward incident that had recently occurred Enid remarked that nurses were not listened to by doctors.

The doctors don't listen to the nurses. That is coming out of inquiries. The nurses said there was nothing wrong with him! [that the service user was bad rather than mad] (Enid: Health Care Assistant: observation)

Enid placed the doctors in the powerful position of the main decision maker regarding risk management. However, according to her the doctors were unable to be effective decision makers as the nurses held important information which was not being taken into account during the decision making process. In Enid's experience doctors disregarded the opinion of nurses, nurses were not able to contribute to decision making and wrong decisions were made because of information deficits. The implication of Enid's comments was that if the doctors had listened to the nurses they might have been able to do something to avoid the incident occurring. Enid affirmed the point she made by citing the findings of homicide inquiry reports. This reference provided a reminder of the potential for incidents to have very serious consequences. She thus provided a warning that unless the nurses were listened to another homicide might happen.

The problems of communication between the nursing staff and other members of the MDT were acknowledged by Marion, a doctor. Marion described how the use of a ward round check list by nursing staff lessened the quality of nursing feedback and affected the attention that was given to the nursing report.

You're sat in on the ward rounds and the first thing you hear is the nurse's feedback isn't it? So it's going to give the tone, it's going to give the feel for the rest of the ward round, so if you have someone who is really monotonous who is reading a piece of paper, you start the ward round thinking; My god, I've got four hours of this! Inevitably you think in your head, and this is being very honest, but I'm sure everyone feels like oh my god, it's going to be like this.

(Marion, doctor: interview)

Marion provided one explanation for doctors not listening to the nurses, as indicated by Enid. She indicated that it was the structural issues of the nursing team being too large for nurses to give their own reports. Also the use of a standard checklist by nurses resulted in a monotonous report which caused Marion to be less receptive to nursing feedback, rather than a professional power imbalance. Thus the nature of the structure and work of the nursing team being unlike that of other members of the MDT caused difficulties in communication. In addition standardised reporting systems created to address the problem of inconsistencies in nursing reports may have unintentionally weakened the nursing voice.

During an interview, Callum a nurse agreed with Enid that nurses found it difficult to work as a member of the MDT and to have their opinions heard. However he then described the MDT that he was working with as one where he feels included and listened to.

It's always been one of the main moans from nurses in fitting in with the MDT, where nurses' views are not really taken on and when nurses feel that we spend more time with patients than the rest of the MDT. I think the team here are very cohesive and we work very well together.

(Callum, nurse: interview)

Callum describes nurses being listened to by the MDT that he works with. He refers to nurses' complaints of not being heard as moans, thus minimising the problem and

conveying a negative image of nurses who complain that their views were not listened to by the MDT. The problem of nurses opinions not being heard by the MDT was not shared by Callum. The division between doctors and nurses is absent in Callum's description. He described himself as being part of the Multidisciplinary team as well as part of the nursing team. He also referred to the MDT as a whole rather than singling out doctors as the decision makers. Thus, although mentioned by many nurse research participants, the disregard of nurses' opinions by doctors as described by Enid was not experienced by all nurses across the service.

Lionel, an OT also provided a different view to Joy and Enid regarding the way that MDT meetings functioned. For Lionel, it was important that the MDT presented a consistent view to service users regarding their treatment. Consistent feedback would preserve the notion MDT decisions regarding treatment were made rationally and reliably. Sam described the MDT reaching a consensus of opinion through discussion rather than the team conforming to the view of a more dominant team member.

So if the patient needs to hear that every member of the team has similar ideas about their treatment then it's important [that team members are all seen to agree], or if you're looking at another aspect of the care and, one or two members of the team aren't sure, hearing everyone else's opinion, either it sets it in your mind that, actually I don't agree with that, and you come up with why, because there are people are explaining why they're thinking things. It's about where you've come from in terms of perspective and your observations. It is a very informally formal team, and I would like to think and I think there is mutual respect in terms of opinion and actual clinical skills.

(Lionel, occupational therapist: interview)

Lionel described the team as respecting one another's views which suggests that he does not share Joy's experience of the MDT being medically dominated. Lionel was able to openly voice his views in the team meetings, and felt that he was listened to. He linked good communication to the quality of relationships in the team, particularly reciprocal respect for a diversity of opinions.

Overall some research participants found the MDT to be stifling, and felt that they were not listened to. However there were also examples of participants experiencing working with certain teams as being inclusive and open to their views and that of each team member. According to one participant at least, for each member of the MDT to have a voice there needed to be good team working with mutual respect between professions. Lionel, quoted above, articulated a need for the MDT to present a consistent, united approach to service users whose cases were being considered.

However individual rationalities were apparent in doctor's interpretation of rules and were evinced through inequities in care provided. Ad hoc interpretations were often inconsistent with one another which challenged the rationality of the clinical decision making process. Tensions were created between the managers and the psychiatrists regarding the interpretation of clinical need. David, a manager described his understanding of the differences in the interpretation of clinical need as the consultant psychiatrists maintaining their power within the organisation.

[consultant psychiatrists are] A powerful group! And I don't see there is any, any desire to have absolute clarity of clinical pathway because clarity makes it difficult for things to be manipulated ... They just want something to be vague you know, then be subject to people's interpretation.

(David, manager: interview)

David was frustrated regarding his inability to manage the consultant psychiatrists particularly regarding the provision of care. David's comments indicate that he views clinical pathways as processes that can be clearly mapped, and that the consultant psychiatrists were deliberately not doing so. In not mapping the pathways David believed that the psychiatrists were defending their power over their professional territories against administrators' attempts to manage them.

Service providers also described self-censoring in response to professional and peer pressure. Martin a consultant psychiatrist welcomed the opportunity to be interviewed so that he could have an opportunity to discuss issues that he would not normally be able to speak about.

I am not going to say good things about psychiatry. You don't get the opportunity to talk like this, sometimes with colleagues behind closed doors.

(Martin, psychiatrist: interview)

Martin welcomed the opportunity to be interviewed for the study as the interview provided an opportunity to speak safely about issues that concerned him. Martin explained that he was unable to talk openly about his concerns with colleagues.

...People feel like that you are not, you are not a team player, you are not working with the Trust, you are causing problems ... We don't talk about this. Very occasionally, sometimes in private sessions, but officially ... no-body ask us these questions. But I'm almost sure - I attended so many meetings where you have this private group and all psychiatrists are troubled, very troubled by the situation.

(Martin, doctor: interview)

The people that Martin referred to were Trust managers and senior colleagues. Similar to Jean, the health care assistant who protected her brothers, Martin believed that if he raised his concerns that he would be blamed for causing the problems that he reported. He described other psychiatrists as sharing his concerns. However, like Martin his colleagues were only able to express their concerns when they are assured that they are in a safe space to communicate; with a private group of colleagues and also behind closed doors. Thus the threat was perceived to come from distrusted colleagues as well as those outside of psychiatry. Martin described psychiatrists as being troubled. However they needed to contain their concerns as challenges to the underlying social order were discouraged by the organisation.

The concerns that Martin felt unable to openly express related to his perception that the limitations of psychiatry were not acknowledged in clinical practice.

We pretend that we are the exact science, which we are not, too much: 'So, Oh this is schizophrenia, oh stupid people couldn't understand it, don't see it, schizophrenia very clear from the beginning, the patient said so' as if it is easy, quick, we are certain about it, we pretend this too much. And we also pretend that we are saviours: 'The patient was going to kill himself unless he ...' And we are encouraged to do this. Usually the advice when you go to the exam, you have always to say that you are worried about the patient killing himself or killing someone else and you have always to say that, you know, you need to take measure to stop this happening - hero, this hero attitude, you are encouraged to play a hero all the time, when actually we are not. Or, if you are not that impressive - and this hero attitude is a big, big problem in psychiatry, you can not tell about it unless you work inside psychiatrist to see how much pretending you do all the time, which we can't really afford, we are not certain. Actually, the best psychiatry decision is something like seventy/eighty percent ... you know, certainty and if you pretend anything more, then you are lying, probably...

(Martin, doctor: interview)

In Martin's view, psychiatrists had erroneously taken on the mantle of god-like protectors of the public from the chimera of the mentally ill patient. He described the psychiatric profession as creating and maintaining an illusion of psychiatrists having the skills and knowledge required to guarantee public safety. Psychiatrists had developed status and power within health care through a colonisation of the high profile areas of violence and risk management legitimated by spurious claims to precision. Martin described psychiatrists taking on a hero attitude, an attitude which he considered to be problematic. In his view decisions regarding risk could not be made with absolute certainty. He argued that the pretence of psychiatrists that they can make accurate predictions and decisions deceives health care professionals and the public into believing that safety has been achieved when it has not. However, he felt unable to

whistle blow on his profession, or raise the issue with the Trust as he felt that he would be labelled as difficult and penalised by his colleagues and the Trust.

An example of a doctor preserving the façade of therapeutic efficacy was recorded during the observation of a MDT meeting. A service user was discussed by the MDT prior to being seen in the meeting. The service user's father was also expected to attend the meeting. He had previously complained about his son's care to his local MP. The doctors appeared anxious about the father attending the meeting and were keen to be prepared for the questions that he might ask. They discussed potential messages that they might give, including reasons for an apparent lack of progress towards discharge or transfer to another ward.

The consultant (Yemi) and the ward doctor (Kwame) discussed what to say to the father before he came into the meeting, and reviewed what had already been said to him in previous meetings. They thought about telling him about the staged process of increasing service users' freedom prior to considering them for discharge. However they discounted this strategy as they knew that the service user would not be given leave due to his risk status.

Doctor, Kwame: *We told him that last time!*

Consultant, Yemi: *We can't go through stages of leave; he won't be given leave at the moment. I won't tell him too much otherwise they will wonder what we are doing here!*

Yemi limited the information that was to be given to the father at the meeting in order to preserve the father's belief in their ability to move the service user towards discharge. In so doing he avoided blame for poor performance through promising little to the father.

During the meeting Yemi explained to the father that the service user had not been transferred to a less secure ward due to circumstances beyond his control. There was

a lot of demand for the beds in the hospital and the service user was not a priority for transfer as he was already occupying a hospital bed. However, the service user was near the top of the waiting list, although an emergency admission would take priority. The service user had been on the transfer list for several months. The father accepted the Yemi's explanation for the delay and then offered to help him hasten the transfer by involving his local MP.

Father: *Will it help if I get my MP involved?*

Consultant psychiatrist: Yemi: *You know I can't comment on that, it is up to you*

It was unclear whether the father was offering to help, or making a threat to involve his MP. Yemi refused the offer, but did not tell the father not to involve his MP. Yemi told the father that it was his decision to make. By drawing on professional propriety Yemi avoided the dilemma of on one hand inciting complaint, and on the other being seen to stifle it. The involvement of the MP would potentially expedite the transfer, but would result in negative and possibly public criticism of the organisation. To advise the father not to approach his MP would potentially mean that Yemi would be blamed by the father for future delays in care. Thus Yemi regulates his communication to limit potential risk to self.

7.6 Summary

In response to organisational crisis arising from the publication of a damning homicide inquiry report, an increasingly blaming culture had been developed in which expectations of staff were unclear, but blame was more readily attributed. This in turn stimulated various reactions from research participants such as solidarity with their brothers, the non-reporting of problems and the re-direction of voice away from official systems to self-forming groups. The organisational response to the threats posed by internal and external review in turn placed pressure on informal groups and individuals within the organisation, which was managed through the regulation of communication. The suppression of communication may be adopted in response to pressure external to the individual or internal calculation and so may not always be a conscious action. Furthermore those who exerted pressure that resulted in censorship might not have intended to silence. People may also have been silenced as an unintended

consequence of the organisational atmosphere, such as the existence of a blame culture, or organisational processes such as standardised routinisation of procedures for ward round reporting.

There were specific points in the organisation where the regulation of communication was overtly reinforced, such as community meetings, MDT meetings, and around disciplinary and complaints procedure. These mechanisms operated where there was a stark contrast in power differentials and where communication was guided by expressed rules, for example between service users and health professionals in community meetings. The regulation of communication also occurred within multi-disciplinary teams around the interpretations and translations into in practice of clinical diagnoses, procedures and risks. Inconsistencies between clinicians in the categorisation and treatment of service users undermined the apparently rational basis of the forensic mental health system. Such inconsistencies were sometimes obscured through the regulation of communication between MDT members and between the MDT and the service user. However, the professional autonomy of clinicians within the MDT was limited by managerial responses to external criticism, thus indicating that professional power gained through the use of technical expertise had been eroded by the findings of the homicide inquiry.

Some research participants expressed a belief that communication within the organisation would negatively impact on their risk status. Service users were concerned about being seen to be clinically riskier if they complained; service providers worried about losing their jobs or being ostracised if they reported failures, or voiced dissent. However, physical and temporal safe spaces for communication were found to exist, where individuals felt able to express views that elsewhere they believed would result in censure, by the organisation or peers. Thus micro-atmospheres, with different climates of opinion which supported individuals to express certain points of view were found to exist within the organisation. Individuals chose where to express their views and share information according to perceived risks to self or the organisation, depending on their orientation. Communication within formal systems, influenced the direction of communication within informal systems of communication and vice versa. Direct challenge to the organisation was observed. However, challenges were made anonymously, via anonymous letters and stories in local newspapers. This would

indicate that service providers felt threatened by the organisation, and powerless to openly challenge how the organisation was being managed.

The analysis of the data revealed a problematic relationship between many although not all research participants and the organisation. The increased regulation of service providers by the organisation indicated that the organisation viewed some service providers at least as potential threats. Research participants' descriptions and behaviours indicated that many had a view of the organisation as a destructive force which they had to defend themselves against by regulating their communication. Ironically the regulation of communication by service providers was often found to impede organisational learning and development. Therefore through regulating their communication to try to manage their risk status and so protect themselves the service providers potentially threatened the integrity of the organisation.

The findings regarding the regulation of communication by both service users and providers to try to manage their risk status are drawn together and discussed in the next chapter.

Chapter 8

Discussion

8.1 Introduction

To understand the meanings of the categories that emerged from the analysis of the data and the implications that they have for forensic mental health care they must be considered in relation to existing knowledge and theory. This chapter reviews the findings of the study within the context of existing research and theoretical frameworks, discusses the limitation and strengths of the study and details the implications for policy and practice. Directions for future work are also explored.

In reviewing the findings this chapter demonstrates that the study offers new insights into the interactions between formal and informal organisational systems of communication in a health care setting as well as new understandings of the process of risk assessment and management within forensic mental health care. The core category of the regulation of communication is explored and dimensionalised in regards to areas of internal, external and wider influences on communication which are presented in relation to the sub category of the management of risk status in Diagram 1. The discussion centres upon the overall storyline of the regulation of communication to try to manage risk status. The regulation of communication was defined as the modification of communication content or direction of communication according to social context, and perceived risks and benefits to self and the social group to which the individual belongs. Risk status was defined as the negotiated but not necessarily consensual level of riskiness attributed to an individual within a social domain.

It is argued that research participants often occupied multiple positions and undertook multiple roles within the organisation, and that these roles often resulted in tensions and conflicts that were responded to through the regulation of communication, a process which often failed to address underlying risk issues. This process indicated the role salience of risks and their management for the individual and the power dynamics within the organisation. The regulation of communication was both shaped by and

shaped risk perceptions which in turn affected the risk status afforded to service users and social group members. Role salience varied between groups of participants and their social context. For example service provider participants regulated their communication in order to manage conflicts between their official role within the organisation and their roles associated with being a member of a self-forming group. Often for service provider participants self-forming groups were most influential. When conflict existed between social group expectations and administrative reporting systems, participants often met the demands of groups by not reporting failures.

The findings of the study were presented in two separate results chapters that focus on the perspectives of two distinctive groups of research participants: service users and providers. However, service providers were further subdivided into frontline staff, managers and providers that had a managerial as well as clinical or frontline role. This review of the findings will highlight and discuss commonalities and differences between the two groups of research participants. Diagram one, below provides a representation of the substantive theory of the regulation of communication to try to manage risk status organised around the core category of the regulation of communication. The diagram also provides a visual representation of the postulated relationships between the categories. The category of the management of own risk status is presented in relation to its subcategories of group, organisational and professional demands to manage or contain risk. These categories are located within the context of an overarching category of the regulation of communication. The categories are closely associated with one another, as indicated by the connecting arrows in the diagram. For example, individuals within self-forming groups described how their actions were partly shaped by internalised professional standards, as well as perceived group pressure. Therefore, the actions of research participants will be considered in relation to internal and external organisational factors contemporaneous to the data collection phase of the study. In particular the impact the publication of a critical homicide inquiry report will be discussed.

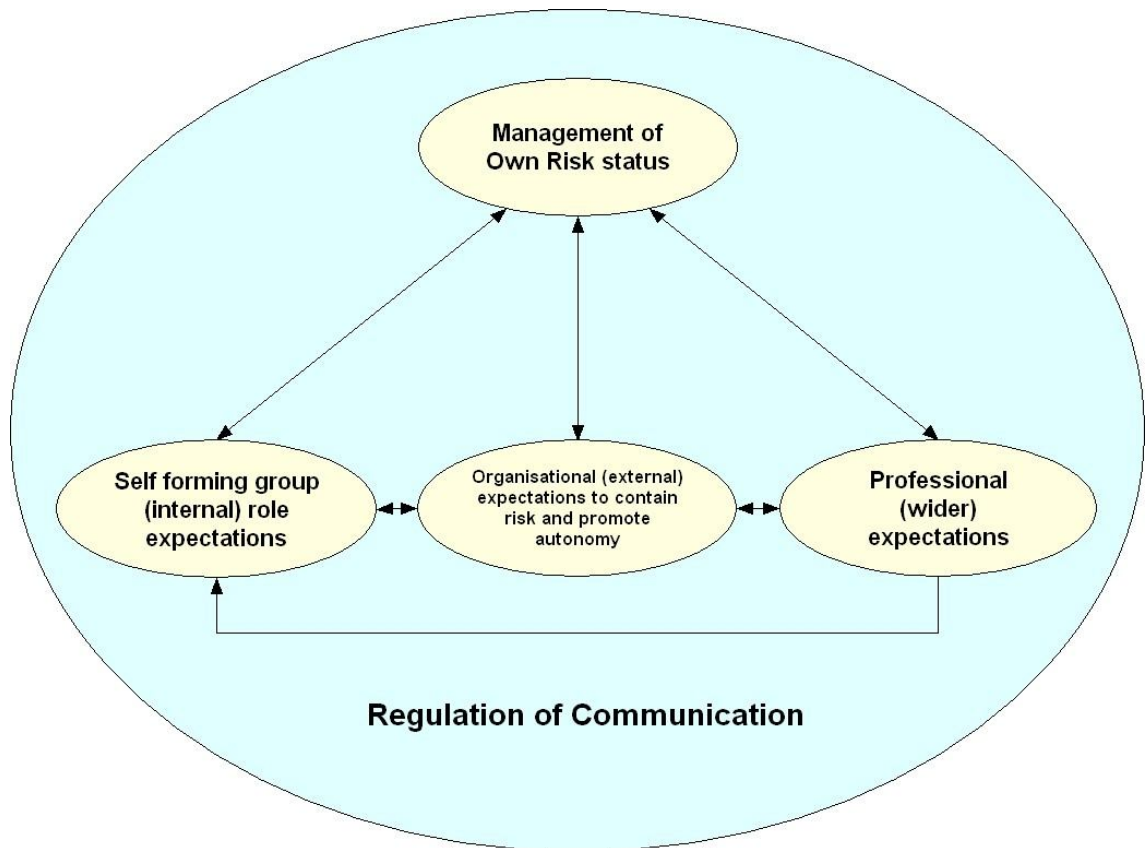


Diagram 2: The regulation of communication and the management of risk status

The identified sub-categories of the management of own risk status presented in diagram one were: self-forming group expectations; organisational demands; whilst promoting service user autonomy and professional expectations to control and contain risk. The relationships between these areas are discussed below in relation to the core category of the regulation of communication.

Firstly the ways in which the regulation of communication emerged from the data analysis will be discussed followed by the synthesised messages arising from service user and provider sources in the context of the categories outlined above. The overarching category of the regulation of communication will be discussed, together with the management of own risk status. Self-forming groups, which for many research participants were most influential will then be discussed, followed by direct external regulatory influences from the Trust, media, and processes of inspection that act through administrative organisational processes. Finally the wider influences on the regulation of communication will be examined. References will be made to data examples in the results chapters, and to the literature reviewed, to discuss service

user, and provider perspectives of the regulation of communication and the management of risk status.

8.2. The emergence of the regulation of communication.

The ways in which the regulation of communication was identified were: self-report, observation, and report of observation by other research participants. These three ways of identifying the regulation of communication are discussed below, with a discussion of the cancellation of a fourth way; the running of focus groups.

8.2.1 Self-report

During interviews, several research participants identified instances when they had changed the content or manner of their communications according to their social context. Often, research participants also supported the observations of the regulation of communication by the researcher, by describing instances when others had not fulfilled their expectations of communication, either through failing to communicate when expected or altering the message according to their social context. On several occasions research participants outlined how they had withheld complaints or chosen not to report problems in order to manage their risk status. Service user participants described how they chose not to report problems or express their dissatisfaction with care to service providers, instead keeping quiet and believed that discussing their problems with other service users. One service user participant, Sam, explained how he felt that complaints would be pathologised by clinicians. He they would be viewed as indicators of mental health problems or negative personality traits and so delay his progress towards discharge (see section 6.3). Two service provider research participants explained why they had not reported problems for fear of being used as scapegoats, and/or of jeopardising positive relationships with peers (see section 6.3). Complaints and problems were then managed by the individual or social group for example a service user participant described a strategy of containing dissatisfaction until after discharge, when they believed that their complaints could be raised safely.

8.2.2 Observation

During data collection the regulation of communication was most apparent in the often dramatic incongruities between the communications of supposedly the same information within different social contexts by the same social actors. For example the communication of risk factors within ward staff groups and between staff and managerial systems. Also absences of expected communications within the observational data indicated that communication had been withheld in one social arena and diverted to another.

However, the discovery of the regulation of communication within the field was mostly reliant on the researcher's expectations of communication. The researcher's expectations of communication were informed by shared cultural practices in her own social and ethnic group, years of professional practice as a mental health nurse and subsequently an educator. As the study progressed and the researcher became immersed within the culture of the forensic service studied; she developed a shared understanding of customs and language used by research participants. These expectations sensitised the researcher to dissonances between observed research participants' behaviours and shared norms and guided the capture of data regarding the regulation of communication. For example, Martin, a service user not raising a previously discussed problem with ward rules in a ward community meeting (see section 6.3). In order to explicate the common sense interpretations made by the researcher, her initial interpretations during data collection and analysis were recorded in field notes and memos. These norms of social behaviour were drawn upon to interpret the actions of research participants. Shared norms included behaviours such as how an individual responds to a greeting, or behaved when another person entered a room. However, many research participants had different cultural and personal backgrounds to the researcher and so may have had different social norms to her and different expectations of social actors. In an attempt to address this problem many of the researchers' interpretations were discussed in the field with the actors themselves or research participants who had also observed the event. Nevertheless, the researcher recognised that the research participants were not always aware of their actions or able to fully articulate their own experiences (Rennie 2000).

Thus the regulation of communication could not be measured in objective terms but recorded according to common understandings of what normally happens within a particular social context, and individual interpretations as to whether research participants felt that they had regulated their communication in order to manage their risk status. Thus the inescapably reflexive nature of the present study needs to be recognised. The use of common sense knowledge by the researcher cannot be avoided. Research is an active process in which views of the world are developed through the use of selective observation and theoretical interpretation (Hammersley and Atkinson 2006). Therefore the researcher is acknowledged as an active part of the research process. The research strategy taken in regards to the active nature of the researcher within the study was discussed within chapters three and four. Examples of the impact of the researcher's presence, her previous employment within the service and her relationships with research participants on data collection were provided within chapters six and seven. The researcher's previous employment within the service and her professional role as a mental health nurse resulted in boundaries becoming blurred between the researcher and many of the participants who also related to her as a colleague, a friend and a nurse. The researcher, often unknowingly moved between these roles, which meant that ethical issues arose during data analysis regarding the consent given by participants for data collected to be used in the study. However, due to existing relationships and the roles that she assumed the researcher was also able to gain access to meetings within the research site which would otherwise have been closed to her. Through undertaking the study the researcher was able to reflect upon her role as a nurse, a lecturer and a researcher and develop an understanding of how her attitude towards mental health care had changed since she had moved into an academic role. This development of a clear understanding of her role as a nurse researcher will be used by the researcher to effectively manage relationships that she forms with participants, and roles that she assumes in future field work.

8.2.3 Report of observation by other research participants

Absences of expected communication were also identified by research participants, who then attempted to make sense of them. An example of an absence of communication being identified by a research participant occurred during a ward round when an occupational therapist (Judy) commented on the nursing report regarding a service user's reaction to their unsuccessful appeal to a Mental Health Tribunal

(section 6.3). The service user had been reported to not to have shown signs of anger or frustration despite their appeal being unsuccessful. Judy queried this response and voiced her expectation that the service user would be frustrated. Using individuals' expectations of another person's response to events, or their social situation is problematic as it is often unclear from where an individual's expectations originate. However, the interpretation of silence or changed communication may itself be viewed as a communicative act (Sherriff 2000). Indeed it has been hypothesised that silence maybe a form of emotion management which is chosen to communicate conflicting or problematic emotions or the inhibition of the expression of what is perceived to be high risk information (Saunders 1985). In the case of the service user participants, dissent and frustration were suppressed, as they were believed to be used as risk indicators by service providers. However, not complaining and being compliant could also be seen to be insincere. Therefore service users undertook more nuanced performances which did not seem to be obviously related to the official mission of safe rehabilitation, or the hastening of progress towards discharge.

Inferences made from the observational data were discussed with research participants during informal interviews, and their response to the researcher's interpretations of individuals' actions was taken into account in the analysis of the data. However, individuals may not be fully aware of their interpretations and actions.

8.2.4 The non-occurrence of focus groups

The running of focus groups might have been a fourth way to explore the regulation of communication. However the focus groups were cancelled. It was planned that focus groups would be held to feed back the findings of the study to the research participants. However, the running of focus groups was prevented by managers within the forensic service, as they feared that reporting the study findings to service users and providers could negatively impact on service improvements that had already been made. The actions of the unit managers had regulated the communication of the findings of the study, effectively censoring the researcher in order to protect the risk status of the organisation. Thus despite the unit managers claiming to have become more open, the findings of the study were suppressed. Lower ranking service provider research participants were frustrated that the findings would not be disseminated and

encouraged the researcher to ignore the unit managers and feed back the findings to service users and providers. Thus the researcher found herself subject to conflicting overt and expressed expectations from service providers from different ranks of the organisational hierarchy. Communication between different ranks of research participants was problematic, with an apparent division existing between high ranking managers and ward based staff, which was straddled, often with difficulty by ward managers and some clinical team leaders. The research enabled anonymous communication to be made between ward staff and managers, bringing to mind the anonymous letters described by a unit manager (see section 7.3). Similarly some service users had expressed a desire for the study to tell people outside the unit what life was like for them. However, a decision was made by the researcher to comply with the request of the managers and not to feedback to research participants, perhaps indicating the power imbalance within the relationships between the researcher and high ranking managers as well as service providers who had low ranking roles within the organisation. The majority of research participants, including service users were not informed of the reason why the findings of the study were not fed back to them. Not holding the focus groups caused ethical problems regarding the relationship between the researcher and the research participants (discussed further in sections 4.9 and 4.12). Also additional confirming and disconfirming data could not be collected. However, the actions of the unit managers in preventing of the feedback of the study to research participants were used as data. The impact of not holding focus groups with participants to discuss the findings of the study upon the quality of the study is discussed in section 4.9.

8.3 The regulation of communication in attempted management of regulate risk status

The regulation of communication emerged from the data analysis as the overarching category, which provided a backcloth upon which the relationships between other categories were set. Communication by many of the research participants was regulated in response to a combination of social pressures and official systems of regulation, which will be discussed below. The emergent grounded theory concerns the regulation of communication in accordance with the actions of self-forming, social groups within the organisation and interpretations of official regulatory mechanisms, and managerial decision making in attempts to manage risk status.

The regulation of communication is complex, having several different forms and being dependent on the actor's social context. Research participants often occupied multiple positions within the organisation, as noted above. For example, several service provider participants undertook clinical, managerial and social roles according to their social context. The enactment of different roles affected the inter-subjective meanings of risk status, and associated joint actions, including communication. Communication was regulated according to the logic of the group that they occupied.

Regulation occurred by communication being directed towards or away from official or social channels according to the anticipated impact on individuals' risk status that resulted from either the communication itself or the location of the communication. Some research participants described sanctions taken by groups or individuals within the organisation against people for communicating information through official channels; in particular information which could result in disciplinary action against group members. Communication was largely regulated by individual and group perceptions of the potential negative consequences. Sanctions included being subject to the disciplinary procedure after reporting failure because reporting fault to official channels was associated with blame; or individuals taking retribution against people who had made complaints against them. Consistent with organisational theory, negative organisational responses to the reporting of sensitive or critical information resulted in the stifling of future communications (Tourish and Robson 2006). However, some participants also identified the need to support others or promote the collective good as reasons for regulating their communication. Thus the findings indicate that social bonds as well as fear of management censure motivated individuals to silence problems. Furthermore the regulation of communication revealed the existence of a social order and power structure both within and beyond the official hierarchy of the organisation.

Communication was largely regulated in practice through selective or non-reporting of information to areas within the organisation such as administrative systems. Examples of this include the non-reporting of security breaches by ward staff (section 7.3), and the non-reporting of complaints by service users (see section 6.3). There are some resonances with previous work regarding censorship within communities such as that of Sherriff (2000) on the communal silence or "cultural censorship" of the subject of racism in social groups in Brazil, and organisational silencing or the non-reporting of

problems (Henriksen and Dayton 2006) (see literature review). However, service user participants also described performing behaviours that they perceived would improve their risk status, such as sitting quietly and waiting (see section 6.3), as well as self-censoring or being censored. Thus, the present study extends previous findings about informal censorship into a domain where management of risk status was a central organisational concern.

As found by Sherriff (2000), communication was often displaced from one system to another rather than being entirely suppressed. Communications were often withheld from official channels as participants felt that the consequences could be to their detriment. Instead critical communications took place in self-forming, informal groups. One service user described this to be meeting with their peers away from the doctors and nurses, who could not be trusted, as a means to keep in touch with their own reality, (see section 6.3.1). Information was encoded and understood by research participants in relation to two distinct domains, terms of self-forming groups and of administrative or clinical systems. Communication which crossed group boundaries into the margins of official administrative systems could be viewed as malicious and dismissed by high ranking managers. For example a senior manager, Eric, dismissed communication from lower grade ward based staff which occurred at the margins of administrative systems as petty gossips and rumours (see section 7.3). This finding echoes research which shows social actors constructing gossip in organisations as a negative influence (De Gouveia et al 2005; Michelson and Mouly 2004).

However, many individuals occupied multiple positions and roles within the organisation and participated in different systems of communication at different times. For example, communication regarding administrative processes was often observed to occur between members of self-forming groups of managers and clinicians during down time such as lunch breaks. During down time managers frequently exchanged information which was specific to their position within the organisation in the form of gossip, with humour often employed to reinforce and share their perception that administrative processes were absurd. Thus in a similar manner to front line staff, higher ranking individuals within the organisation circumvented the administrative systems of communication through their communications within self-forming groups.

8.3.1 The regulation of communication within self-forming groups.

Consistent with risk systems theory the organisation emerged from the data analysis as a combination of largely uncoordinated sub-groups, with each group focussing primarily on a particular risk object (Japp and Kushe 2008). Communications occurred in distinct forms specific to sub groups which then enabled them to effectively perform their social function, of supporting and protecting group members. For example communication within self-forming groups of front line ward staff was often in languages other than English and drew on cultural references that were specific to the ethnicity of the group members. This strategy insulated communication within the group as non-members were unable to understand the language used. Furthermore the use of cultural heuristics in decision making and references to family strengthened relationships between members. For example referencing cultural norms when explaining decisions made to manage risk (see sections 4.9.2 and 7.3). Members of some ward based self-forming groups were observed to refer to one another as members of a family, brother, sister, or auntie. A practice that was attributed to African culture and criticised by senior members of the nursing team as it negatively impacted upon their ability to objectively undertake risk assessments:

Calling each other "auntie" is an African thing ... They are losing their objectivity

(Aaron, nurse manager: interview)

The data highlights an incongruity between the officially espoused technical rational system of assessment within the forensic service and the use of cultural heuristics in decision making by members of staff and service users (see section 3.3.5). Furthermore research participants were often uncomfortable with the use of personal cultural references that differed from their own, which reinforced the differentiation between groups which formed along cultural lines. Many research participants commented on the impact on communication and team working of an apparent dominance of nurses from one ethnic group working within the service, this is discussed in more detail below.

Consistent with symbolic interactionism, individuals were responding to differing role expectations generated through their interactions with different social groups. Many research participants experienced tensions arising from conflict between their social and official roles within the organisation. Some research participants described consciously regulating their communication in order to manage role tensions arising from conflicting role expectations which impacted upon their risk status, whereas as others were observed to regulate their communications between different social groups and roles unconsciously. Thus, as with previous research, the study found that health care professionals working within forensic mental health settings experienced role conflicts (Mason 2002). However the main conflicts that the provider participants reported were those that occurred between the need to fulfil competing official and socially mediated role expectations rather than that of balancing security and therapy. This may indicate that the conflicts associated with balancing of security and therapy were taken as given and so not reported, or that during the crisis that followed the publication of the homicide inquiry report the conflicts between protecting social groups and undertaking official roles became particularly acute (see section 4.6).

Responses to role conflict provided an indication of the role which a research participant favoured, as they could not always avoid choosing which role expectations to fulfil. In many instances this may have been a conscious decision according to the perceived impact on risk status, and was demonstrated by research participants being able to explain why they chose to act or communicate in the way that they did. However, some participants were unaware of how they regulated their communication and found it difficult to explain why they did so. For example one service provider participant was surprised when during an interview he realised that he directed his social communications and requests for support to service users rather than to his colleagues. Thus the self is multidimensional, constructed of many different roles, which the individual responds to according to their social context and cognitive frame.

According to Stryker and colleagues the regulation of communication provides an indication of where research participants' roles sit within a salience hierarchy (Stryker, Owens and White 2000). Salience is defined as the likelihood that an identity will come into play in a variety of situations, in this case in the regulation of communication to manage risk status, as a function of it's properties as a cognitive schema (Stryker, Owens and White 2000: 28). For example when service provider research participants

were in similar situations, decisions to report or deny failure were shaped by the salience of conflicting roles. Often for service provider research participants their role as a member of a self-forming group had greater salience than their professional or employee role, and so they often chose not to report failure (see section 7.4). One service provider research participant who did not follow the rules of a self-forming group and challenged a colleague's poor practice described how she had been ostracised by her peers. Another service provider described his fears that due to not following group rules he would be used as a scapegoat for errors made by group members (see section 7.4.1). Group responses to perceived threats to the group provided an indication of group rules and also shored up the informal social order, for example of frontline staff within ward settings. Therefore the cultures existing within the organisation and power dynamics are illuminated by the present study as shared values, meanings, symbols and pressures within social groups; elicited through observation and interview (Geertz 2006).

It was unclear to what extent groups formed according to existing internalised roles and role expectations, such as those identified by Fagermoen as professional nursing values (Fagermoen 1997). These values then reinforced the salience of roles such as that of nursing and shaped interpretations of social objects, or whether external social group pressures and fear of threat to risk status informed role salience. Many research participants described how external social pressures informed actions designed to manage their risk status. However, others described how they had formed groups with others who shared their professional values, such as the provision of patient centred care, which then informed their interpretations of social objects such as risk status and their regulation of communication.

Furthermore the regulation of communication was reflexive and recursive as interpretations of the actions of high ranking individuals informed individual and group action, which then shaped future frames of understanding and action, which were then acted upon by high ranking managers. During interview, several research participants described reflexive loops, whereby their interpretations and actions were informed by previous interpretations and the logic of the social group within which they were situated. For example the application of understandings of previous managerial responses to similar incidents were described by one research participant as informing her current interpretations and expectations of managerial decision making. The

perceived punitive response of managers was cited by the participant as a reason to conceal any errors or failures that they or their colleagues might have caused (see section 7.3). Therefore the actions of high ranking individuals such as service managers were interpreted and meanings developed of that action as a social object, by lower ranking service providers. These interpretations may or may not have been expected by the manager who originated the communication. This finding builds upon Gluckman's (1968) view of gossip as means of defining and perpetuating social groups as it connects official responses with gossip and vice versa. Thus both systems of communication interact with one another through unexamined and censored tensions, holding back the service from achieving its therapeutic mission.

Research participants' role hierarchy affected the regulation of communication to try to manage his or her risk status, according to the persons' present role and social context. Role salience impacted on organisational safety culture and the core business of the organisation management of risk. It is argued that the position of roles within an individual's salience hierarchy and so the regulation of communication were affected by self-forming groups internal to the organisation, and wider external influences to the organisation, which appear as key categories in the model depicted in Diagram 1. Research participants' attempts to manage their risk status through regulating communication occurred within the context of a failing organisational hierarchy, within which risk was used to protect the institution from *predatory* individuals; and the corresponding actions of people and self-forming groups to defend against perceived threats from the organisation (Douglas 1990). Each category will be discussed below in the context of the regulation of communication and research participants' identities. However, firstly the difficulties of researching the regulation of communication will first be discussed.

8.3.2 Difficulties with exploring the regulation of communication

The study of the regulation of communication, presents a potential conundrum in terms of observation and theory building as it is difficult to define and observe (Sherriff 2000: 117) Inferences made during the analysis of the data are problematic from an epistemological point of view as common sense assumptions must be made regarding the interview data and observed actions of research participants. There are limits to

individuals' knowledge of their actions. Individuals may not always be able to link their beliefs with their actions. Therefore, research participants interviewed regarding their observed behaviours may not be able to articulate the meanings behind their actions.

The observation component of the study enabled non-linguistic expressions to be recorded in field notes. Practical understandings that are often difficult to express verbally were examined alongside interview data. It must also be borne in mind that actors do not doggedly follow the rules of their embodied cultures, and so their actions might not indicate internalised organisational rules (Moore and Sanders 2006). However, following a symbolic interactionist approach, it is assumed that the meanings that individuals have for social objects are conveyed through the presentation of symbols such as gestures or language. Individuals respond to those gestures according to the meaning that they have for them. The study therefore provides a limited insight into individual's private inner worlds, such as internalised roles, but an extensive insight into public group life within the organisation. Public group life encompasses research participants' actions, interpretations and interactions, and their impact on the mission of the forensic mental health service studied. Therefore although inferences regarding individuals' inner, cognitive frames were problematic, the recording of the occurrence of the regulation of communication was relatively unproblematic. The ways in which data regarding the regulation of communication was collected were discussed above. However, the organisational culture studied must be considered to be conceptual, created out of the meanings for human actors, rather than an empirical fact (Moore and Sanders 2006).

Despite being a problematic concept, the regulation of communication offers an insight into the cultural drivers for joint social actions within an organisation. Furthermore, the regulation of communication illuminates the dialectic between agency and social structure in the context of risk status, and in the context of the present study, the organisational functioning of a forensic mental health service. It is recognised that, the phenomena described will change as the organisational culture evolves. In line with the canons of grounded theory the study provides a detailed description of the conditions of the research participants' actions, and responses to changing conditions (Corbin and Strauss 1990). A more detailed discussion of the study in relation to the canons of grounded theory is provided in section 4.9.

The regulation of communication was found to have potentially profound and wide-ranging consequences for the operations of the organisation as well as the fulfilment of the mission of the forensic service. One major consequence for the forensic service of the regulation of communication was the limitation of organisational learning due to the non-reporting of failure or risk indicators by lower ranking staff. For organisations to be sensitive and responsive to failure lower ranking individuals must be able to report errors without the fear of censure (Weick and Sutcliffe 2007). Furthermore negative responses to the communications of failure or staff gossip may promote the formation of self-organised groups with disparate agendas. These processes provide ways for service users and providers to manage their anxieties, but may also foster distrust between different groups and individuals within the organisation (Paine 1967, Gluckman 1968, Michelson and Mouly 2004). This distrust may then hinder the team working required to meet the difficult objectives of forensic mental health care. The consequences for individuals with respect to their risk status are discussed below.

8.3.3 The management of own risk status

The management of own risk status is a key category that emerged from data collected across service user and provider research participant groups. Front line nursing staff, managers, clinicians and service users described drawing upon social norms to interpret how they were viewed by their peers or people in positions of power and also of judging the risks posed by others. Participants thus described being judged as well as judging others in terms of risk. Risk judgements afforded individuals a social status to which they responded. Service user and provider research participants regulated their communication to present an image that they felt would favourably affect how they were perceived by others, and so improve their risk status. The concept of the regulation of communication to manage risk status could be applied across different groups of research participants, although the nature of specific concerns varied, depending upon individuals' role positions.

8.3.4 The situational nature of risk status

Risk status was found to be dynamic, being shaped by the interpretations of individuals within a particular social context. For example a service user's risk status may be

defined differently according to which members of staff were on duty and on which ward they were placed. A service user in an acute ward may be assessed as suitable to move to a less secure rehabilitation ward, but when he is transferred to that ward he will be assessed as being high risk compared to the other service users, and his freedom restricted. This situation was observed to cause problems with tacit agreements between service users and providers in the management of risk status (see section 6.3). As with Buckingham and colleagues' study (2008) risk assessments were apparently based on a wide range of idiosyncratic factors such as the way that the staff felt towards the individual as well as the use of statistical risk assessment tools. This use of individual frames of risk resonates with the cultural approach to understanding of risk as being shaped by embedded social influences rather than being a reified object to be measured and contained (Lupton 1999). Service users' risk status was also shaped by their peers according to the potential threat that they were believed to pose other users or the integrity of a self-forming social group. The communicative strategies that many research participants used to manage their risk status within self-forming groups were similar to those that participants described using to attempt to silence risk within formal organisational systems. Service users' diverted communications that they felt could affect their risk status in one system, for example diverting complaints from official systems to self-forming groups that lay outside of administrative systems of communication. As discussed below many service user and provider research participants interpreted the actions of high ranking managers and administrative systems as harmful in the sense of not contributing to the quality of service provision.

8.3.5 Ways in which risk status was managed, by service user research participants

Several service user participants described deliberately performing in a manner which they believed would be interpreted by service providers and their peers as an indication that the user presented low risk to others. They did so by regulating their verbal as well as behavioural forms of communication with the aim of promoting their progress towards discharge. The lower the risk status ascribed to a service user the greater the level of autonomy they would be allowed, and as their level of autonomy increased the service user would progress towards discharge. Service user participants described regulating their communication to manage tensions that arose when they felt that they needed to act in a certain manner for service providers to assess their risk as low, but

they knew their actions would be interpreted negatively by their peer group. The regulation of communication to manage risk status in the context of judgements by service providers and peers is discussed below.

8.3.6 Service users' risk status in the context of service provider assessment

Risk was overtly constructed by service providers in terms of the threat posed by service users to themselves and others. The main risk object for staff was the risk of service users re-offending, for service users the risk of continued detention. Service users and providers engaged in a process of measuring and containing risk with the aim of reaching a point where the service user was deemed fit to be discharged. In this process, riskiness was largely deemed by service providers to be an intrinsic quality of the service user, a risk status which could be assessed and measured within the context of the service users' environment. To be discharged the service user would need to earn a low risk status by demonstrating behaviours or expressing attitudes that would be interpreted as low risk by service providers. The risk category in which service users were placed was officially designated through evidence based risk assessments undertaken by service providers. However, often assessors did not confine themselves to technical approaches to risk assessment based on formal measurement instruments, and service users were afforded a socially situated risk status. The awareness of service providers of a disjunction between formally measured risk categories and socially determined risk status was highlighted by one service provider participant who voiced a concern during a ward round that clinical decision making regarding risk was very off the hoof (see section 6.2). Furthermore several service user participants described how they sought to meet the perceived organisational requirements, through playing the risk game of being quiet, visible and compliant in order to lower their risk status, criteria which do not easily map onto recognised statistical risk factors that are used within mental health care (DH 2007) (see section 6.3). Thus the tacit priority for service users who wanted to be discharged as soon as possible was to perform obedience to the system rather than internalise change (Rhodes 2004). In addition for the forensic service to process a flow of service users they needed to be regularly discharged so that beds would become available for new admissions and as an indicator of the therapeutic success of the service. To be discharged the service user would need to attain low risk status. To discharge a service user who was not deemed to be low risk could be considered to be negligent by

professional groups (Heyman 2010b). Furthermore as has been shown in homicide inquiry reports (NHSL 2008) if a service user who had not been assessed as a low risk then went on to reoffend it is highly likely that the service concerned would be severely criticised. Thus both service users and providers had an interest in reducing service users' ascribed risk status.

However, not all service users readily engaged with playing the risk game. Some were reluctant to display the compliant behaviours that were perceived to be required to lessen their risk status, some refused to engage with the game at all, and others failed to understand the tacit rules which had to be spelt out to them. One service user participant (Carl) described how he resented having to behave in a compliant, gregarious manner which he found uncomfortable. He felt that not to play the game would be detrimental to his clinical progress, and so he grudgingly complied with ward rules, and spent time with other service users (see section 6.3). Another service user participant, (Mark) was observed to challenge the regime by refusing to engage with his MDT and play the game. He refused to accept that he was mentally unwell and refused to participate in ward activities. The challenge to the regime caused the psychiatrist in charge of Mark's care to express the need to play the game in terms of Mark getting what he wanted, rather than in terms of therapeutic change (see section 6.3.1). Thus the needs of the service user and the service were met without posing a threat to the service user's sense of self, or clinicians' professional frameworks. The risk game was also observed to unravel in another case, when a service user research participant felt that the clinical team had breached the tacit contract between service users and providers in which service users to fulfil the requirements of the service and providers enable them to progress towards discharge. At this point the normally unspoken expectations of service users to reduce their risk status were openly stated, re-negotiated and reinforced.

8.3.7 Service users' risk status in the context of their peers

As mentioned above, a further example of the regulation of communication in order to manage risk status was that of service users managing their social status in the context of their peer groups. Service users were found to attempt to manage their risk status through regulating their communications in order to maintain their membership of self-

forming groups. Occasionally successfully negotiating the reduction of their risk status with service providers was found to conflict with the demands of service user peer groups (see section 8.3.6). For example, to agree with the number of smoking breaks provided by the wards and so show compliance with the ward rules, would be to conflict with service user demands to increase the number and length of smoking breaks, thereby undermining service users' solidarity and so threatening the strength of the service users' voices (see section 6.3). Thus some service user participants needed to respond to their interpretation of service provider decision making and actions in order to progress towards discharge, but also to engage with peers in ways which distances self from a subservient position (see section 6.3.2). To be seen to act in a way that conflicted with service users' actions against the regime could result in verbal or physical bullying by peers. Therefore, service users needed to walk a precarious path of demonstrating compliance to reduce their risk status with service providers, but also supporting other service users' activities that challenged the forensic service regimes. Some service users also experienced an inner conflict as they could not express their autonomy in the short term, choosing to suppress their feelings of frustration and dissent until they are discharged when they can regain their autonomy more fully (see section 6.3).

The regulation of communication according to social context was particularly problematic for service users who were under constant assessment by service providers, but also needed to live with peers whose values conflicted with those of the organisation. Inconsistencies in communications resulted in uncertainties for service providers undertaking assessments which they often construed as possible indicators of deception and therefore concealed underlying risk. Some service user peer groups were also found to disapprove of conflicting communications by peers and to label the person who was not consistent in their communications as fake (see section 6.3.1). The term fake was one which was commonly used a by service users when discussing individuals whose behaviour was not consistent between different social situations, such as when a service user acted defiantly towards institutional rules when they were in the company of their peers but then took on a passive service user role when they believed that they were being assessed by service providers. The term fake was also associated with a person who displayed apparent strength that didn't exist, or made a threat that they later failed to enact. An example given by a service user participant in order to explain the use of the label of fake was that of a person carrying a gun that he did not have any intention to use. Being labelled fake lowered an individual's status

within their peer group as they could not be trusted to act in ways they had indicated. An individual labelled as fake represented a potential risk to the group, as their indications of group loyalty could not be trusted. Service user research participants often identified strongly with their social situation, and acted to protect peers, social groups or the organisation as well as themselves from perceived threats. However, as discussed below, research participants' loyalties and role expectations often conflicted and decisions needed to be made regarding which area to defend.

From a symbolic interactionist perspective the term fake, as used by the service user participants is misleading as the self is understood to be dynamic, being shaped by individuals' interpretations of their social frames (Blumer 1969). Therefore within a symbolic interactionist frame individuals cannot be understood as fake but rather, that they have multiple roles and respond to their role expectations as defined by their social context. However, for many research participants responding to different role expectations represented a threat to social groups and so potentially to risk status. To manage this threat group members acted negatively to individuals whose behaviour was inconsistent with expectations. The individual would then need to demonstrate capitulation or defend against group actions. Thus through the use of the label fake, social order was negotiated and reinforced by the group of service users who were observed (Perinbanayagam1991). Therefore the use of pejorative labels such as fake may be understood in terms of negotiating order by articulating social boundaries and expectations of social cohesiveness.

8.3.8 Service providers' management of risk status: ward based staff

Service providers were found to manage their risk status with respect to their accountability as health care professionals and providers, and their need to maintain relationships with members of their social group. Thus the risk objects for service providers included the loss of professional status, the loss of employment, the loss of positive relationships with colleagues. The availability heuristic (Tversky and Kahneman 1974) may be used to provide an explanation for service provider research participants' decisions not to use administrative systems to report failures. Service provider participants often described how they drew upon their knowledge of previous events to interpret the actions of high ranking managers and the functioning of

administrative systems in response to current criticism of the organisation. As the organisation had not been supportive of individuals who had been implicated in previous incidents participants felt that it was better not to report problems as this could result in them being blamed rather than supported. A service provider participant, Jean, an HCA provided an explanation as to why she would not report problems to the managers (see section 7.3). Jean described how following a previous incident she believed that the managers within the organisation had become intolerant of failure. Jean had chosen to protect herself from an expected managerial censure by not reporting failure. She felt that to report failure would result in her being blamed, and losing her job. This view was shared by Max, a therapist who depicted a reactive and punitive managerial team that was desperately attempting to contain problems and so avoid further negative publicity.

Service provider participants feared that they may be subject to disciplinary action. This mirrors the experience of service user participants who reported risk indicators to clinicians, such as experiencing symptoms of mental illness. They were likely to have their autonomy restricted and progress towards discharge delayed. Furthermore most ward staff that participated in the study sought to maintain their relationships with their peers, often at the expense of organisational learning. For example Barbara, a care assistant, (see section 7.4) chose to keep [her] mouth shut and not report a breach of security despite being the designated security nurse. She did this to maintain a positive relationship with her colleague, Jean. It would seem that for many staff participants the role of friend or member of a self-forming group had greater salience than their official mission of promoting safe rehabilitation. In consequence, many ward based service provider participants chose not report risk indicators which they believed would be to their detriment, in relation to their employment, and social relationships

8.3.9 Service providers' management of risk status: unit managers

Service providers who occupied a managerial position, those who managed at an entirely organisational level and those who also occupied a clinical post were also found to regulate their communication to manage their risk status. For example being careful about discussing culture or ethnicity as they feared that to openly voice concerns regarding specific ethnic groups might result in them being accused of

racism, a label that could attract social censure as well a formal disciplinary action (see section 7.4.1). However, they were also found to manage other service providers' communications in order to protect the organisation and the therapeutic mission of their profession. Managers within the service were conscious of the political climate, and the need to protect the reputation of the organisation in order to protect themselves. One manager highlighted the tensions that existed for staff in balancing autonomy and safety. They needed to provide patient care, but also protect the public, and the organisation.

There are political pressures. Some staff don't realise the importance of public safety...you can do everything for your patient but if the public gets hurt you are accountable.

(Claude, Manager: observation)

The manager makes it very clear where the balance of security and therapy lies, and hints at what might be the implications for staff that do not prioritise public safety. The individual is accountable, rather than the service. The managerial view that individuals are accountable for failure may then result in fewer clinical risks being taken or fewer failures reported by ward staff (Tourish and Robson 2006).

Therefore, the regulation of communication was found to be shaped by participants' perceptions of risk to self, and organisational values, their understanding of the forensic service's therapeutic mission and risks to individuals with whom they were connected.

8.4 Internal influences on the regulation of communication to manage risk status: self-forming groups

The internal arena comprised self-formed groups within the organisation. Self-forming groups influenced organisational micro climates of communication by generating internal factors such as meeting an individual's need for support and conformity, as well as imposing sanctions for placing the group at threat (see discussion re: self-

forming groups in section 3.3.11). The impact of internal factors on micro climates of communication within the forensic service studied is discussed in more detail below.

Self-forming groups within the organisation shaped the climate of communication for service user and provider participants. Self-forming groups were social groups that developed from relationships built between individuals rather than through formal designation. Self-forming groups were largely developed within existing divisions of the organisation, with the service provider groups mostly being aligned to the wards on which they worked or their professional group. Exceptions existed, with relationships and groups forming across operational lines within the organisation. Indeed one service provider participant (Jack) remarked that the only support he received was from service users, rather than his colleagues (see section 7.1). A common example of groups and connections forming between service users and providers forming along 'family' lines will be discussed below.

Self-forming groups often formed according to attributes of individuals such as their ethnicity, language, or therapeutic framework. Group activity and permeability were found to be influenced by members' interpretations of the threats posed by the organisation and benefits associated with group membership, in particular the provision of support and belonging. The actions of self-forming groups were also found to be influenced by external factors such as critical media coverage, which were translated by many staff group members, and understood in terms of potential threats to continued employment. The fear of unemployment informed social group pressures for service provider participants, influencing factors within the organisation to manage risk to the group and thus to self. Internal organisational pressures were described by research participants as affecting them through perceived threats of group exclusion or being used as a scapegoat for organisational failures. Therefore factors internal and external to the organisation interacted with one another and affected how individuals regulated communication and managed their risk status (see section 7.3).

Self-forming groups reacted to and were shaped by their perception of threats created within the organisation from external arenas such as professional regulatory bodies, as outlined in Diagram 1 (see section 7.3). For most participants social pressures exerted

by self-forming groups had the greatest influence on their regulation of communication. Communications associated with their own risk status or that of their peers were often diverted from official to informal systems in order to protect self-forming groups and their members. Such groups motivated participants to regulate communication by offering close supportive bonds between group members, but also through the fear of exclusion. Thus threat and the regulation of communication acted in a similar way to gossip in defining group values, as well as strengthening and perpetuating social groups (Gluckman 1968). However the suppression of communication of failure may result in future problems for the organisation. Henriksen and Dayton (2006) contend that organisational silence presents a hidden threat to patient safety. They argue that individuals adapt their behaviours and judgements to fit those of their social group, which results in poor practice going unchallenged. Group outsiders described feelings of exclusion, but also perceived groups to be hostile, with the potential to scapegoat non-members for the failings of members (see section 7.4.1). Group formation was experienced as coercive as well as supportive and protective. Most research participants were members of one or more informal groups. However, several research participants were not group members and described how they felt pressured to join a group, or to avoid challenging individuals who were members of a group. The researcher's status was positioned between that of being an insider and outsider to the field, and varied according to her social context. The researcher was often accepted as an insider by ward manager and clinician groups, but excluded from ward based staff groups. On several occasions self-forming groups were identified and described by individuals who were excluded from the group, or had chosen not to become a member. Thus the negative and coercive nature of self-forming groups may be overly represented in the data set. However, it is clear that groups were experienced by research participants as both positive and negative social influences within the organisation.

8.4.1 Self-forming groups as 'family'

Some members of ward based groups referred to one another as members of a family, thus indicating the existence of close, supportive relationships. The use of family references was attributed by many service provider participants to African culture. A high proportion of the ward based nursing and domestic staff were ethnically African. Data on the diversity of the staff group was not collected, but 61% of service providers

interviewed were from ethnic groups other than white European (further demographic information about the research participants is available in section 5.2.5 and appendix 1). However, several white British ward based staff and service user research participants were also observed to make references to family relationships, and were also referred to as family members, such as dad and auntie. It seems likely that this symbolic framework pervaded the non-management levels of the organisation from African culture.

Supportive and protective relationships were often observed to be marked with the use of references to family relationships. Jean, a service provider participant spoke of protecting her colleagues, whom she referred to as brothers. During observation several service provider research participants referred to one another as brother or sister. Service providers were also observed to call one another brother. It was common for references to family relationships to be used to bridge the service user, provider divide. Service users, both white British and black African were often observed to refer to female members of nursing or domestic staff as auntie, male members of staff as brother. However, references to family were not found to be used by service users with individuals who occupied high ranking positions within the organisational hierarchy or young members of staff. The use of family references, conveyed status to an individual within a hierarchy based on family ideals. Through the use of family references individuals signified the quality and meaning of the relationship for example by demonstrating deference to an individual by referring to them as dad or auntie. As with families young members of staff, even if occupying a high status rank within the organisational hierarchy were not given the status of senior family members by service users.

The use of the term auntie signified a special relationship, one where the service user felt that the nurse had gone beyond their role and had taken care of them. Also calling a nurse auntie conveyed respect, as a senior family member. Unlike service providers, peers were not referred to as brother or sister by service users, possibly as a commonality of experience or status was absent. Senior members of the organisational hierarchy were not referred to as family members, possibly as they often occupied positions which were more powerful, and meant that they provided less direct care than ward based nursing staff. Also some senior managers were found to discourage the use of family references, perceiving them to be undermining the use of technical

approaches to care delivery. The use of family references signified connections that blurred the boundaries between service users and providers symbolically undermined the supposedly objective, technical approaches to care delivery and enabled a privileged form of communication to occur between family members. Perinayagam (1991: 91) notes that “many if not all of the formal properties of discursive acts will in fact be determined by the roles that parties to an interaction assume”. Therefore, the creation of family roles through the use of family references would be expected to affect inter-subjective interpretations of social objects and associated joint actions. As discussed above the use of family names and references symbolically promoted a form of relationship between participants which appeared more relaxed, caring, and supportive than that associated with the formal rank or role of the individual within the organisation. Family associations also denoted solidarity and authority within the social group, which then characterised and limited future communications, such as the reporting of failure or complaints. Therefore conferring, and enacting of roles through joint communicative actions indicated an individual’s status within their peer group. However, the metaphor of family may also be used to indicate the negative connotations of family. Families may be viewed as controlling, or abusive, and may even hold people back, preventing them from leaving home. The solidarity of a family group may not always be experienced positively or have positive consequences for family members. The coexistence of social groups with official operational systems within the organisation was problematic as the officially espoused technical approach to care was challenged by the formation and logic of self-forming groups. Also, group interpretations of organisational responses to external pressures as threats to group members, could be damaging for the organisation. For example under threat self-forming groups exerted pressure for members not to report problems, which then in turn subverted technical approaches to organisational risk management and inhibited organisational learning.

The data demonstrate how the roles of individuals within the organisation constrained or promoted discourse (Perinayagam 1991). The physical structure of the organisation and the positions in which people are placed promoted or limited discourse and the relationships between different groups of actors. For example ward based routines and professional expectations limit the opportunities for service users and providers to develop relationships beyond those required to undertake therapeutic activity. However, service users and ward based service providers spent many hours in close proximity, and as demonstrated above some developed connections with one another,

in this example in terms of being a family. Managers occupied high ranking positions within organisational hierarchy that often required the interaction between them and other service providers or users to happen in a manner that was consistent with their status. Furthermore many unit managers were physically located in offices that were separated from ward staff and service users. Higher ranking managers occupied offices above the wards, which, due to security measures were difficult to access by frontline staff and off limits for service users. Also the activities of high ranking managers rarely involved frontline staff or took place within ward areas. Thus in most instances meetings with high ranking managers and frontline staff would need to be planned in advance rather than occurring serendipitously. The location of unit managers shored up the social order within the service through maintaining distinct physical and relational divisions between most of the unit managers and ward based individuals.

However, some clinicians and high ranking managers were observed to be members of self-forming groups, which included ward based staff. Self-forming groups were found to serve as a safe means of communication, away from the perceived threat of disciplinary action, a means of support and a place to share and test out interpretations of organisational policies. Often, as discussed above, such activities took place during down time, such as lunch or coffee breaks where managers would meet with colleagues and staff with whom they would not normally work and discuss politics and decision making within the organisation. Therefore joint interpretations and communications that took place within self-forming groups sometimes included managerial service providers as well as service users and ward based staff.

8.5 External influences on the regulation of communication to try to manage risk status

The external factors that influenced the regulation of communication encompassed regulatory forces from outside the forensic service that acted directly upon the organisation. Influences included those from the Trust central administration, the Home Office (ministry of Justice) Department of Health, wider NHS initiatives and the press. It was largely service provider participants who were directly affected by external forces. However, service user participants were affected by service providers' responses to

external influences. For example directives from the Home Office and central Trust administration regarding the restriction of service users' leave from the unit had a significant effect on service users, particularly as the decision to restrict service users' leave was a blanket one which would not be influenced by service users' conduct. In a similar manner to service users, low ranking ward based staff were also influenced indirectly by external factors. For example ward staff were indirectly influenced by directives from government bodies and central Trust administration which were translated and disseminated by high ranking unit managers to low ranking staff. However, further translation of external messages occurred on the 'shop floor'. Trust and Home Office directives focussed on human fallibility rather than systemic failure, thus seemingly protecting the reputation of the service at the expense of service providers (Green 1999; Butler and Drakeford 2005). Furthermore, managerial directives regarding security following the publication of the homicide inquiry report were interpreted by ward staff in terms of blame, exclusion from decision making, threat to employment and risk of future disciplinary action (see section 7.3). As previously discussed, such staff interpretations then influenced perceptions of provider and user risk status in regards to the organisations' reputation and service providers' job security. These interpretations then influenced the strength and formation of social groups and the regulation of communication. Thus external factors affected how safety and autonomy was balanced by service providers at the research site. The setting of the balance between safety and autonomy is widely considered to be a problem central to the provision of forensic mental health care which creates tensions that affect the practice of all health care professionals working in forensic mental health services (Mason 2002; Burrows 1993; Peternelji-Taylor 1999). External factors had a great impact on the practice of service provider participants. Following the publication of a damning homicide inquiry report the focus of service providers shifted more towards public safety, and the protection of the organisation. This change in the balance between security and therapy in turn influenced participants when choosing whether to communicate security failures or indicators of risk within official channels. To report risk would enable the service to respond to protect the public and the organisation. However it was believed by many participants that in a perceived hostile organisational climate of blame that to report failure would result in being subject to disciplinary action. The managerial response to external threat paradoxically resulted in the suppression of communication of information considered vital to risk management (Weick and Sutcliffe 2007). Therefore external pressures to manage risk directly and indirectly stimulated and reinforced the regulation of communication within the organisation.

External regulatory forces were found to shape the managerial, hierarchical, physical and procedural structures of the organisation. For example the national standards for Medium Secure Units (MSU) dictate many of the physical and procedural security measures within the unit (DH 2007), and the NHS pay structures as well as professional guidelines shape official roles and their status within health care organisations. These structures, procedures and routines may be considered as systems of networks and understandings (Feldman and Rafaeli 2002). In which relationships were built between individuals as they worked together with colleagues to fulfil official organisational requirements, for example nurses working together in a ward to deliver direct patient care. In these relationships individuals were observed to engage in joint actions including the transfer of information and interpretations of organisational structures and procedures in order to address everyday situations and so fulfil role expectations. Thus the external guidelines supported organisational structures and routines. However, the process of external and internal regulation itself was also found to impact upon the regulation of communication. Inspections of the forensic service by external agencies and the monitoring of staff activity such as their timekeeping (see section 7.3) impacted upon how ward staff viewed higher ranking members of the hierarchy and regulated their communications with them. For example measures taken by managers to improve security following an escape from the unit included requiring all staff to wear belts to which to attach their keys. This measure was taken without consultation with staff. The nursing staff interpreted this action as senior managers blaming and punishing ward staff for the escape and resisted the wearing of belts. The resistance was met by a letter being issued to all staff warning of disciplinary action and pay deductions if they failed to bring a belt to work. The nursing staff eventually complied with the managerial request, and ceased to complain to the managers but continued to voice their dissatisfaction with the situation in the form of gossip and discussion within safe social groups. Therefore, in the face of disciplinary action organisational silencing of complaint occurred, but as with cultural silencing the dissatisfaction and discomfort with the situation remained unresolved (Sherriff 2000). Staff interpretation of managerial actions shaped the values of self-forming groups and so would inform future regulation of communication.

A paradoxical relationship existed between the social organisation and the standards measures and monitoring imposed from outside. This paradox was echoed by the relationship between service users and clinicians in the monitoring and reporting of signs and symptoms of risk and ill mental health. The process of standard setting and

monitoring aims to improve the quality of the service provided (Sally and Donaldson 1998). However, in response to regulation and the monitoring of standards failure was often unreported by staff, and so could not be addressed by the organisation. Official organisational channels of communication were often those where performance was monitored and audited. Common systems used for communication included those for complaint or incident reporting. Often instances of the regulation of communication observed or described by research participants clustered around these systems. For service users regulation of communication was often reported to occur in regards to the use of the complaints system. These systems represented a juncture between different roles for research participants, and a link between external and internal systems of regulation. For example complaints procedures for service users defined their role as consumers rather than patients and declared their dissatisfaction with the service. The users' complaint may then be reported to external organisations such as advocacy services and would be dealt with and audited by central Trust administration. A service user making a complaint about a service provider may then experience censure from other service providers, a deterrent for making future complaints official (see section 6.2). Therefore, such channels of communication could affect an individual's risk status and so were treated with caution by research participants. The management of an organisation may be considered to be a form of symbolic action (Perinabanayagam 1991). Managerial decision making and internal and external regulatory mechanisms constituted a form of symbolic interaction with service providers and users. As described above, the data revealed that the meaning that many particular service provider participants placed on the managerial response to external threats to the organisation impacted upon their communicative actions.

In a similar manner to providers' regulation of communication in response to managerial actions the regulation of communication by several of the service user research participants was influenced by their interpretations of clinicians' decision making. Their decisions were supposedly based upon service users' reported symptoms and behaviours and organisational standards, such as those for containing risk. However, clinicians also needed to act on managerial directives issued in response to external pressures, including reviews of the service by external groups such as the Health and Social Care Advisory Service, following the publication of the homicide inquiry report. Following the publication of a homicide inquiry report all service users' leave from the unit was restricted, and consideration given to providing more escorts for service users who had to leave the unit, for example for hospital

appointments. Unexpectedly, service users were not observed to change their strategy of not reporting problems and not complaining about their frustrations with their care. It is unclear why service users did not complain. However, clinical teams explained to service users that changes in unit rules regarding their leave status were due to the managerial response to the homicide inquiry report, and not clinical judgement. Thus complaining about their care would not change their situation, and service user research participants expressed concerns that their complaints could be pathologised (see section 6.3) and so negatively impact upon future clinical decision making regarding the level of autonomy that they were to be afforded.

Neither managers nor clinicians understood research participants' actions of displacing complaint and dissatisfaction as a response to the actions of high ranking individuals. One manager believed that service provider gossip was malicious and occurred because individuals' failed to fully understand the managerial strategy (see section 7.3). However, this may be unsurprising as gossip was rarely positive as it was largely constituted by the discussion of problems or critical thoughts by staff and service users that were suppressed in official channels (see section 2.4.1). In an interview undertaken towards the end of the period of data collection a manager recognised that there were problems with communication between senior managers and lower grade staff, and described how unit managers were attempting to address them (see section 7.3). It would seem that a shift in managerial attitudes towards staff dissent had taken place during the period of data collection. Following the publication of the homicide inquiry report managerial decision making had been viewed as punitive by ward staff. However towards the end of data collection the managerial approach to working with staff seemed to change with more open communication between lower and high ranking service providers in the organisational hierarchy being encouraged. It is unclear why this change had occurred. However, action taken by the trade unions on behalf of ward staff was described by one participant as being a driver for change. The trade union took forward the grievances of its members to the unit managers without revealing the union members' identities. Thus anonymity, this time achieved through union representation, was again used by service providers to safely challenge high ranking members of the organisation (see section 7.3). Managerial action and the regulation of communication were influenced positively and negatively by external forces, those that happened in response to the homicide inquiry report and also negotiations by trades unions that occurred in response to the redirection of staff complaints.

Therefore external regulatory and monitoring systems influenced organisational decision making and so the regulation of communication in order to manage risk status. Managerial and clinical decision making was a symbolic action to which service user and provider participants responded, often in ways that were not expected or understood by managers or clinicians. Service providers and users presented their self and declared role salience in discursive acts. However, participants also entered into relationships with other selves that were members of other social groups, which often resulted in tension and conflict. In regulating communication participants were implicated in acts other than that of the moment, which for many research participants proved to be problematic (see section 6.3.2) (Perinabanayagam 1991)

8.5.1 Wider, indirect influences to regulate communication to try to manage risk status: professional pressures

Wider external influences are those that indirectly act on the organisational communication. Forensic mental health services have multiple stakeholders from different organisations and communities who may have differing views on service provision. These include local residents groups, advocacy groups, the Home office, professionals working within the criminal justice system and third sector organisations. The forensic service reacted to the needs of all stakeholders. However at a ward level most service provider participants reacted to professional standards and regulation and interacted with local media. Governmental and professional bodies act directly on forensic services through various processes including as described above standard setting and audit. However, service providers were also influenced by external agencies through training and for professionals the standards set by regulatory bodies. Often these influences were internalised by service users and only became evident when conflict occurred within the organisation such as between managers and/or members of different professional groups. An example of such a conflict is that of a social worker using their professional framework to construct a service user's problem, and developing a different view to that of a doctor who had drawn on the medical model to inform her opinion. The social worker would defend their position during MDT meetings. However, when the social worker was in the presence of the service user in question they would endorse the doctor's view (see section 7.5). Thus indicating that for the social worker the need to agree with the doctor was greater than that of following their professional values. This example reflects previous research regarding the struggle between professional values, the construction of patient problems and

team power dynamics within forensic mental health services (Davies et al 2006). These dynamics are reflected in the experiences of one of the doctors (see section 7.5) who felt that they could not openly voice their frustrations with psychiatry for fear of professional and managerial censure. This example highlights the power of professional values and regulation over the doctor's practice despite his own personal values. Thus for some research participants a tension existed between their desire to act spontaneously and fulfil internalised roles and desires and the need to fulfil multiple social expectations and roles within the organisation both of which were in part informed by external pressures (Blumer 1969).

Service user and provider research participants interacted with the local press, providing information, threatening to provide information and responding to negative reports in the local paper. The majority of research participants were conscious of the negative press that the unit received in the local newspaper and were anxious about the impact upon the service and for service provider participants, their continued employment. In the wake of the publication of the inquiry report service users on leave were escorted by staff in case they were approached by reporters and ward staff were reminded not to talk to the press. However, problems experienced by staff who felt unheard by their managers began to appear in the press, and an anonymous letter voicing the dissatisfaction with the service was sent to the press as well as members of the Trust board, and the Home Office (see section 7.3). Service provider participants also reported that service users had called the local paper to inform them that an incident had occurred. In this atmosphere when informed that he would have to pay for his own dental care a service user threatened to call the press and expose the poor conditions with the service. The free dental service was reinstated. Therefore the local press enabled some service users and providers to anonymously voice the concerns that they had silenced within the organisation. In this way the source of the information could not be traced, but also the report was jointly owned, not only by the paper but by unknown people working within the service. through the use of the local press disenfranchised service users and providers were able to safely influence managerial decision making. Complaints that had been suppressed due to expected punitive responses by managers and clinicians could be voiced. However, the local press could be used to anonymously attack unit managers. Critical exposes of the forensic service also placed a greater emphasis on risk management and the containment of dangerous patients, thus potentially pushing the service to focus on security rather than therapy.

Not all of the wider external influences on the service filtered down to a ward level. Those that did were central to the participants' professional role and shaped clinical practice. However the wider influences were not all one way. Service users and providers were able to use external sources of influence to voice their concerns and challenge organisational practices.

8.6 Summary and conclusions

The present study provides a picture of a forensic mental health service as a complex and dynamic system which seeks to balance the needs for security and public safety with service user autonomy and therapy within a changing political landscape. In attempt to achieve the forensic mission of providing rehabilitation whilst ensuring public safety, service providers and users undertake several roles which may result in internal and interpersonal conflict which in turn affects individual's risk status. In the present study, role tensions and risk status were managed by service providers and users through the regulation of communication. Commonalities were found to exist between service user and provider participants in regards to how they regulated their communications in response to perceived power imbalances and their risk status. The regulation of communication may be understood as a means to demonstrate the performance of role expectations within a particular social frame. It is argued that the phenomenon of the regulation of communication is an interpretive action which is undertaken by individuals to modify or protect their risk status. In situations where roles conflict, how an individual regulates their communications provides and indication of role salience and power relationships. Contrary to the views of several research participants the regulation of communication may not always be a deliberate or intentionally deceptive action, but may occur subconsciously.

Research participants regulated their communications in order to meet the perceived priority of the role demands in their social frame. Role priorities were judged by research participants according to perceived power relations and potential threat to self arising from communication in a particular social context as well as their individual schema. Several research participants perceived that to act in a manner contrary to that which was expected of them in a particular social context would increase their risk status which could potentially result in harm to themselves. For example a service

provider who openly followed official and professional guidelines to report failure against the pressure of their peers to suppress problems might find themselves viewed as having a high risk status by both managers and peers and be ostracised or worse, used as a scapegoat by social groups (see section 7.4.1). Thus although power often followed the official organisational hierarchy power was also held and exerted by service user and provider groups at the lower levels of the hierarchy. Power used by self-forming groups to influence group members to regulate their communication was particularly evident within the lower levels of the organisational hierarchy. At a ward level peer pressure was described by research participants to be largely exerted to protect against expected punitive action by high ranking managers. However, social groups were also formed by high ranking managers within the service which then influenced how communication was regulated to manage the risk status of individuals and the organisation.

Risk status is a virtual social object; risk is not 'real' but 'becoming real', when the risks considered to be posed by an individual become real they are no longer risks but untoward incidents, and their risk status changes (Van Loon 2002). Risk status is constructed through joint actions and shared interpretations of individuals' language and behaviours within their social context. The management of the risk status by an individual may occur in response to indications of role expectations by their assessor. In this way control may be actively exerted over the individuals' behaviour. Risk status was not a static, standalone entity but an object which was modified according to actors' interpretations and so differed according to the social context and position of the individual within the organisation. Therefore although prima facie risk was reified within the organisation, and positivistic approaches employed by service providers to measure and contain risk, it emerged from the data analysis that many participants engaged with risk as a socially constructed virtual object. From a risk systems theory perspective, social groups within the organisation had created their own risk objects, the interpretation of which influenced how research participants understood their and others' risk status and thus how they regulated their communication. However, risk objects and their management were also influenced by external events and pressures from sources such as the media or professional bodies.

Interpretations of managers' and clinicians' decision making in response to external pressures were acted upon by self-forming groups through the organisational

hierarchy. In the present study managerial actions in response to external criticism and scrutiny were interpreted by many ward staff to be punitive and blaming. These interpretations often resulted in the suppression of dissent and non-reporting of failure by ward staff. Problems therefore went unresolved. However, anonymous means of communication were employed by service users and providers to express their feelings of dissatisfaction with the service. The impact of the interpretation of managerial and clinical action was largely ignored by high ranking members of the organisation who focussed on the official message that was being given rather than how their actions might be interpreted.

In linking the regulation of communication with risk status in the context of organisational systems the present study highlights the difficulties inherent in the provision of forensic mental health care. Organisational systems at the forensic mental health service were ultimately self-defeating. To effectively manage risk whilst providing care the organisation relied on the reporting of sensitive information by service users and providers. However the organisational response to the reporting of problems was considered by many research participants to be punitive and which discouraged future reporting. For example if a service user reported symptoms of illness they would then have their leave taken away from them (see section 7.3).

Furthermore a dichotomy existed between official business and informal social aspects of the organisation. Managers within the service did not appear sensitive to the social aspects of the organisation, and were overtly dismissive of service providers' and users' inter-subjective interpretations of organisational processes. However, managers as well as low ranking service providers were members of self-forming social groups which influenced organisational functioning through processes of interpretation and the regulation of communication.

8.6.1 Summary of conclusions

1. Risk is constructed by service providers and users in terms of their own and others' risk status.

2. Risk status is shaped by an individual's response to conflicting role expectations as well external factors that they cannot influence.
3. Communication is regulated by service users and providers to try to manage their risk status.
4. The regulation of communication is an interpretive action and so is dependent on social context.
5. Social context is shaped by self-forming social groups as well as the official organisational structure and external pressures.
6. The regulation of communication provides and indication of power relations and role salience within the organisation.
7. Self-forming groups at a ward level were most influential on the regulation of communication by low ranking service providers, but were also important to service users and at other levels in the hierarchy of service providers.

8.7 Recommendations for practice

Following an exploration of the theory generated by the present study in the context of existing knowledge, three recommendations have been made for the future practice of health care professionals working to provide forensic mental health care. These recommendations concern organisational systems of communication, risk status, and managerial practices. They are outlined below.

8.7.1 Recommendation 1: Organisational systems of communication

- a. It is recommended that systems for safe communication, that will not negatively impact on an individual's risk status be created within forensic mental health services.
- b. Critical upward communications are encouraged through the development of systems of communication that are penalty free for the informant.

Attempts had been made at the research site to introduce systems for communication through the introduction of complaints procedures and the provision of an advocacy service. However, the study indicated that these systems reinforced the regulation of communication, in particular the suppression of communications of failure and dissatisfaction. Safe communication had in part been achieved through the use of anonymous systems of communication via union representatives, anonymous letters and advocacy services. However, although anonymity brought safety for individuals it also eroded the credibility of the complaint made. To be effective, organisational systems of communication need to be truly open and safe. Godin and colleagues (2007) draw on theory developed by Habermas to call for a participatory approach to be taken to service user research. It is argued that open communication will create possibilities for service users to shape forensic mental health care services through communicative action (ibid). The findings of the present study highlight the need for opportunities for an open participatory approach to be established in the provision of forensic mental health care for both service providers and service users.

8.7.2 Recommendation 2: Risk status

a. The dynamic that exists between the regulation of communication and risk status to be recognised by service providers.

To improve upon current systems of risk assessment and measurement in forensic mental health care risk status needs to be recognised and understood as dynamic social construct which is shaped through communicative actions rather than an absolute entity to be measured and contained. In so doing a greater understanding may be gained by clinicians and managers as to how risk is constructed and yields responses according to an individuals' social frame.

b. The impact of service providers' risk status, and the focus on different risk objects by informal groups and formal systems on the provision of mental health care must be recognised.

The impact of the risk status of service providers, on the provision of forensic mental health care needs to be recognised in the planning and management of service delivery. Awareness also needs to be developed that official and self-forming groups of service providers may respond to different risk objects, which then impacts upon both the provision of care and the safe functioning of services. It is hoped that risk status may be openly addressed in terms of service provider action and threats to the service and service delivery as well as threats posed by service users to self and others.

8.7.3 Recommendation 3: Managerial practices

a. It is recommended that managerial and clinical practices become more reflective. A greater awareness of the impact of serious incidents and the managerial response on the regulation of communication to manage risk status needs to be developed at all levels of the organisational hierarchy

c. For risk to be effectively managed by service users and providers there must be a recognition of how organisational systems both perpetuate divisions within and between service user and provider groups and encourage distortions in communications relating to sensitive or high risk areas.

8.8 Strengths and weaknesses of the study

It is important that others are assured of the worth of the study in order that it might impact on the future delivery of forensic mental health care. Therefore the strengths and weaknesses of the study will be discussed. The areas which strengthened as well as weakened the study were those of the researcher's former insider role, the use of a single site and the theoretical framework used. These areas are discussed below.

8.8.1 Former insider role of the researcher

Three years prior to commencement of the study, the researcher had worked at the research site in a managerial role. The researcher was therefore positioned as a former insider to the research site. Former insider status enabled the researcher to gain

access to the research site. Obtaining research access to a secure forensic service is problematic due to risk and the high profile nature of many of the service users. Undertaking an observational study in any mental health setting is problematic and fraught with ethical considerations, perhaps indicating why so few observational studies have been undertaken of secure forensic mental health services. Therefore the researcher's former insider role was invaluable in gaining access, and enabling the study to happen. Furthermore the researcher had maintained positive relationships with some ex-colleagues which enabled her to gain greater access to activities within the site.

However, some research participants responded to the researcher in a manner that impacted negatively on the collection and analysis of the data. Some lower ranking research participants were secretive, talking away from the researcher, although not withdrawing their consent to participate in the study. Others related to the researcher as if she were in her previous role, asking her for advice, or to take action regarding poor nursing practice. One manager welcomed the researcher's observation of nursing practice as they felt that it would keep ward staff on their toes, on another occasion during a ward round a senior consultant psychiatrist asked the researcher to sort the nursing team out as their reports had not been completed in time. This caused some difficulties between the researcher and unit managers, and reinforced the apparent suspicions of lower ranking staff that the researcher was a management spy. One service user participant sought out the researcher to talk to her after he had been informed that she had previously worked as a manager within the unit. To some research participants the researcher's current and previous professional roles gave her more credibility and enabled data collection, and afforded her marginal status to self-forming groups. However for other research participants, the researcher's former managerial role affirmed her status as an outsider and a potential threat. The researcher also felt that the service user research participants placed a burden of trust on her; that she would give them a voice within the world both within and outside of the forensic service. However, the researcher was later prevented from voicing the concerns of the research participants by the unit managers (see section 4.9.8).

Therefore, as with previous ethnographic studies undertaken by other researchers the personal characteristics the researcher affected the activities that occurred within her presence (Van Maanen 1988). Some research participants seemed to engage with the

researcher in regards to her being a nurse, a lecturer or that she had previously had a managerial role within the unit. There had been a three year break for the researcher between their role in the forensic service and the commencement of the study, so she had been able to step back from the social and organisational context when analysing data.

However, due to the researcher's back ground as a nurse and level of immersion in data analysis and collection it quickly became difficult for the researcher to stand back from the data and consider alternative explanations and interpretations. This was addressed through the use of the constant comparative method, in which the data was fractured, and preconceived ideas or assumptions were considered against the data. Verification and validation of the data was considered in terms of plausibility, which was indicated by themes repeatedly emerging from the data. This was evident when saturation was reached and no new themes emerged from the analysis of data, and so data collection was ceased. Discussion within research supervision also helped the researcher to stand back from the data and explore different interpretations.

8.8.2 Ethical considerations

As discussed above, the present study required the researcher to spend extended periods of time in the field. During this time, as is common to most studies that use an ethnographic approach, relationships were built with research participants that affected areas such as consent and the potential for unconscious exploitation of the participants by the researcher (Atkinson and Hammersley 2006). Over the months that the researcher spent in the field relationships with participants developed, changed, and power was negotiated and re-negotiated. As the period of observation progressed complex ethical issues often emerged for the researcher around whether data should be recorded and to what extent the participant had given consent for their words and actions to be captured in the study. Judgements made by the researcher regarding what was legitimate action to take were made by drawing upon ethical frameworks and discussions during research and clinical supervision. Ethical issues are discussed in section 4.12.

8.8.3 Single site case study

The strengths and weaknesses of the present study mostly centre on the study being restricted to one research site and largely relate to issues of the transferability of findings to other settings, and thus the value of the study in terms of impact upon practice. The limitations in terms of the generalisability of the findings of the study are discussed in section 4.10.

8.8.4 Theoretical framework used

The use of symbolic interactionism to underpin the analysis of the data afforded both strengths and weaknesses to the study. The use of a symbolic interactionist approach enabled front line practice issues which were grounded in participants' experiences to be drawn from the data and explored. Insights were gained into the daily lives of individuals working and residing in forensic mental health services. In focussing on micro-social structures symbolic interactionism enabled risk and the mission of the forensic service to be examined, whilst remaining connected to service providers' practice and users' experiences. Thus direct recommendations for the future practice of health care professional working in forensic mental health care could be generated.

However, symbolic interactionism pushed the study down the route of focussing on microsocial phenomena. The focus on microsocial structures proved to be a weakness as well as a strength, as although individual experiences and meanings could readily be examined it proved problematic to relate the microsocial structures and interactions within the forensic service to wider macro-social structures. The limitations of symbolic interactionism relating to the macro social structures (for more detail see section 3.2) are well documented. These limitations were apparent in the author's mind whilst undertaking the study and so are not apparent in the thesis. However, the concerns that the researcher had with using symbolic interactionism will inform future work including the decision to re-analyse the data using a different framework.

8.9 Future directions

It is intended that future work will have two distinct directions; one which will focus on the data and findings of the present study and one which involve undertaking new research. Firstly research activity will focus on disseminating the findings of the present study, and re-analysing the data using an alternative theoretical framework. Secondly research will be undertaken to further develop the theory generated by the present study.

8.9.1 Dissemination of the research findings

The researcher has an ethical responsibility to ensure that the voices of the service users and providers who participated in the study are heard (ref). Therefore further work will be undertaken by the researcher to negotiate with the research site to present the findings of the study to current service users and providers as well as research participants. It is intended that the findings of the study will also be disseminated through academic and professional publications and conference presentations. Ethical considerations regarding publication and the anonymity of the research site are discussed in section 4.12.4.

8.9.2 Analysis of data

As discussed in section 8.8.4 symbolic interactionism enabled the study to be grounded in the day to day experiences of the research participants, and discover theory from which recommendations for the improvement future practice could be generated. However, the next stage to develop the present study would be to re-analyse the data set using a different theoretical framework. It is intended that a theoretical approach such as that of Foucault which would enable the limitations of symbolic interactionism to be addressed through taking a macro structural perspective will be used to re-analyse the data. This additional analysis is beyond the scope of this thesis, and therefore will be undertaken post-doctorally.

8.9.3 New research

The present study discovered that there are commonalities in service users' and providers' experiences of forensic mental health care. The theory discovered was that both service users and providers regulate their communication in an attempt to manage their risk status. The focus for new research is to further develop the theory generated in the present study. Additional work would be done to gain a greater understanding of the factors that affect organisational communication and the management of risk status. In particular the impact of self-forming groups and managerial responses to failure on the approaches to communication would be explored. The theory generated that communication is regulated in an attempt to manage risk status would be explored with the aim of developing more specific recommendations to improve forensic mental health care.