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COMMENTARY

‘Forensic service user’: transitional identity or life sentence?

COMMENTARY ON … WORKING WITH OFFENDERS†

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† See pp. 178–187, this issue.

SUMMARY

It has been suggested that a recovery-focused approach and treatment under the Mental Health Act are mutually exclusive, hence the limited applicability of ‘recovery’ in forensic psychiatry. This is heightened if recovery is seen as a ‘model’ that does or does not fit, and lessened if seen as ‘values-in-action’ that need reinterpretation in context.

DECLARATION OF INTEREST

None.

Dorkins & Adshead’s thoughtful exploration of the applicability of ‘the recovery model’ to offender patients (2011, this issue) illustrates the difference between the critique of the engaged clinician and that of those who stand outside practical responsibilities for such issues – and they are understandably cautious.

In the UK, recent consensus statements (Future Vision Coalition 2009), policy (Department of Health 2010) and guidance (Sainsbury Centre for Mental Health 2010) have confirmed the centrality of a recovery approach across mental health and social care services. The approach has arisen largely from the life experience of people with psychotic conditions who have spent time in adult services (see, for example, Rethink 2009). Dorkins & Adshead rightly question the simplistic implementation of this approach to working with offender patients without further interpretation and modification.

In commenting on their article, I’m aware that I do so from the viewpoint of a rehabilitation psychiatrist who has worked only in open settings and this has made me think. We are frequently involved with the same person at a different stage of their care pathway. Alignment or disconnection of our operational philosophies represents the bridge between secure and open settings that enables or confounds a path to safe and successful community living.

The purpose of detention under the Mental Health Act – balancing safety with recovery

The *Code of Practice* to the Mental Health Act 1983 (Department of Health 2008) states that the guiding purpose of the Act is to:

1 minimise the undesirable effects of mental disorder;
2 maximise the safety and well-being (mental and physical) of patients;
3 promote patients’ recovery; and
4 protect other people from harm.

These same principles apply to people detained in forensic and other services. Clinical and personal recovery are two sides of the pursuit of well-being for such people. In my view they describe complementary processes of recovering from a problem, difficulty, disorder or illness (point 1), and recovering to a valued pattern of life and living, with restored capacity and confidence to be in control of your own life (point 3). I agree with the authors’ difficulty in accepting Slade’s (2009) apparently simple ranking of personal recovery over clinical recovery because these lie in a complex and highly individual interrelationship with one another. Getting over problems and getting into life can vary independently or be intimately interdependent considerations. The potential dissonance with recovery perspectives for people detained under the Mental Health Act arises in thinking how to maximise their well-being (point 2) while preventing risk of harm to others (point 4). The attendant dangers of risk management are either in causing additional harm through obstructing the path to personal recovery or colluding with possible repetition of harm through inadequate accounting for safety needs; it is not an easily resolved dilemma.

The trouble with models…

The authors repeatedly refer to ‘the recovery model’ and reflect on ‘what challenges forensic services users offer the model’. Although some authors have developed models of recovery based on qualitative

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research (Ralph 2005; Andresen 2006), recovery is better considered as a values-led outcome-focused approach that offers a hope or goal for people and an orientation for practice, practitioners and services. Recovery clusters with social inclusion (Royal College of Psychiatrists Social Inclusion Scoping Group 2009), personalisation (National Mental Health Development Unit 2010), promotion of self-management (Hill 2010) and the pursuit of well-being (Slade 2010). Recovery is not a model or technique or a new sort of therapy; services cannot 'recover' anyone, but can provide the supports, opportunities and preconditions. This broader conceptualisation of what recovery is about sheds a different light on many of the difficulties raised (Davidson 2006). It also poses a complementary question along the lines of 'How does a recovery-focused approach challenge current forensic services?'

Dorkins & Adshead's concern for staff sharing personal experience in forensic settings is answered in the original 'Ten Top Tips' (Shepherd 2008: p. 9), which suggests using peer as well as professional examples, advising mental health practitioners to 'identify examples from [their] own "lived experience", or that of other service users, which inspires and validates their hopes'. The opportunity for staff to turn their experience into expertise may be emerging as a key issue in the workforce development agenda for recovery-focused services (Roberts 2011), and the possibility of employing peer workers in forensic services of the future raises additional, as yet unanswered, questions.

Their observation of difficulty in being socially inclusive, when society is so rejecting of its offenders, may find response in thinking of the forensic campus as the community for people while detained there and focusing on opportunities for meaningful reciprocal roles that support self-esteem, responsibility and agency.

Their concern for an unbalanced emphasis on 'the patient as expert' finds response in acknowledging plurality: although people are sometimes called 'experts by experience', it may be more accurate to consider them 'experts in their experience', alongside those who are experts by training and through research. Valuing these simultaneous perspectives gives a three-dimensional view but how they rank will then depend on other personal and contextual variables such as legal responsibilities, capacity and choice.

The discrepancy of viewpoints that Dorkins & Adshead describe between forensic service users and staff may be almost universal and definitional for detained patients. Some recovery outcome tools, such as the Recovery Star (Mental Health Providers Forum 2008), are structured to facilitate recognition of these differing viewpoints as a support in working on recovery. The issue is not being asked to accept that 'the customer is always right', but to consider the person as part of the solution, not just the problem. For example, the Wellness Recovery Action Plan (WRAP; Copeland 1999) is a paradigm structure for supporting personal recovery and is unusually empty of content. It is not a creed so much as a framework to support purposeful exploration, through which people construct their own self-help manual on the basis of what works for them. It is therefore supportive of personal discovery, responsibility and commitment. However, there remains the pivotal question of how this could work for people who have been taken out of society, detained by others and who may lack any or all of these characteristics. It is not easily resolved, but the reframing of professional activity to be focused on working to support people in successful self-management must still apply, as previously examined in this journal (Bora 2010).

Working in the dark: pessimism or realism?

People who have been detained in forensic services inevitably have more complex recovery needs. The risks that they present in association with antisocial acts and severe psychiatric disorder carry the dual stigma of both their diagnosis and confirmation of public fears about the association between mental illness and violence. Although the authors are undoubtedly compassionate and committed practitioners, I have difficulty with some of their negatively charged suggestions such as the obligation they see upon healthcare professionals to share in the social condemnation of their patients' antisocial intentions and values and their advice on the need to balance hope with pessimism. Condemnation carries an implication of ongoing adverse judgement, disapproval, censure and blame, and pessimism links with expecting the worse, gloominess and hopelessness (Brown 1993).

There is clearly a need to alloy hope with realism if fantasy is to be avoided, but I'm less sure about 'pessimism'. However, my discomfort is exactly the issue that Dorkins & Adshead regard as inevitable for those engaging in supporting recovery for people caught in these most difficult of human circumstances. I suspect that we could do with spending more time together working on how best to connect up our varying care pathway perspectives and in learning from one another's experience.

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Forensic service users – caught in a story?

People who become 'forensic services users' have not always been and (most) will not always be such. The wider concern to combat stigma seeks to avoid conflating personal identity with service utilisation or diagnosis and emphasises that people who use services are, firstly and primarily, people.

The authors begin by citing Anthony's (1993) broadly accepted definition of recovery, which speaks of 'the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness'. They have illustrated how, for offender patients, personal recovery also implies growing beyond the catastrophic effects of their own behaviour and of being required to accept a problematic new identity as a forensic service user.

A narrative critique on our own practice would observe that, whereas becoming a forensic service user could and should be a transitional support to enable recovery, there is an overwhelming requirement that people inhabit a socially sanctioned story of their experience and are required to continually rehearse it in successive semi-public performances.

Paradoxically, the release of a forensic service user may depend not so much on 'getting over it' as on reassuring others that they have incorporated prescribed new meanings into a semi-permanent modification of their identity and self-image, which risks being a life-sentence restricting hope and opportunity. From a narrative perspective this appears to be an invitation to adopt a 'problem-saturated story' with an attendant puzzle in how such people will ever recover a secure sense of personhood beyond an over-determined identity of patienthood. However, the weakness of a 'strengths-based approach' may be in de-emphasising critical variables, which undermine safety and well-being if unattended, and so risk fulfilling Satayana's (1905) warning that 'Those who forget the past are condemned to repeat it'.

Although the roots of the recovery movement in psychiatry (Davidson 2010) can be traced back to humanistic philosophers, social activists and compassionate clinicians over the past couple of hundred years, it is the personal testimony of individuals that has fired and fuelled the contemporary recovery movement. Picking up the authors' question of 'where next for forensic recovery' and stepping a little beyond the end of the paper I was left wondering about the experience of people who do recover life, relationships, community integration and a self-affirming identity after such experiences. It would be fascinating to know how they manage it and what lessons could be drawn from that to inform both non-collusive peer support and progressive, recovery-supportive practice.

To be continued…

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