Article

Stigmatization and Marginalization of Forensic Psychiatric Patients

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Abstract

In this article, we will explore evidence for structural and public stigmatization and marginalization of forensic psychiatric patients within mental health services and the human rights justice system. It can be argued that patients in secure and forensic services (often referred to as mentally disordered offenders) are potentially the most marginalized and extensively stigmatized of all patient cohorts, and that the extent to which they are discriminated against should not be under-estimated. We will also consider the potential for breaches of the Human Rights Act (1998) and associated injustices which may present in the treatment of these individuals, and how praxis can be improved so that harms are remedied and well-being and mutual respect improved.

Keywords

stigmatization, marginalization, forensic, rights, discrimination, jurisprudence

Manifestations of Stigmatization and Marginalization

Stigma

Stigma can be described as structural, public, and self (Corrigan & O'Shaughnessy, 2007). Structural stigma manifests at the organizational level via policies and practices which may act to compromise the human rights and opportunities of the members of the stigmatized group, public stigma manifests in popular beliefs and attitudes toward

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members of the stigmatized group and comprises three forms; discrimination (behavioral), prejudice (affective) and stereotypes (cognitive), and self-stigma which is the stigma that members of a stigmatized group of individuals internalize (Fox et al., 2018).

Mental health stigma can pervade mental health care being enacted by both qualified professionals and trainees (Horsfall et al., 2010). In its widest sense, a non-stigmatizing human rights-based approach to mental health needs to be inclusive of cultural, social, economic, and political influences and their impacts. It also needs to address unwarranted health inequalities and the needs of more marginalized groups. Mental health services and other agencies have a legal duty to respect, protect, and fulfill all human rights in mental health care and support (WHO, 2022).

Mentally disordered offenders who receive care and treatment in secure and forensic mental health services can experience a significant degree of stigmatization and discrimination on multiple fronts increasing the nature and extent of the precarity they can suffer (WHO, 2010). The foremost argument for upholding human rights standards therein, beyond the legal necessity is that compliance with human rights obligations acts to increase the likelihood of individuals complying with societal norms and expectations. Similarly, disregard for human rights is likely to have the opposite effect. Treating individuals with fairness and humanity and in non-stigmatizing ways can enhance public safety.

Forensic patients form an "othered" social group due predominantly to the dual stigma associated with both the mentally disordered and criminal identities. The popular narrative that mental disorder is inevitably linked to dangerousness pervades forensic mental healthcare and leads to mentally disordered offenders being labeled as enduringly risky regardless of whether there is evidence to support this at the individual patient level. Such stigma is chronic and likely to remain with patients post-discharge and affect their re-integration into the community; influencing housing, occupational, and social opportunities. Mental health stigma has been associated with barriers to obtaining employment and accommodation and poor mental health recovery outcomes (Livingston et al., 2012). This can be exacerbated by the limited and often distorted publicly available information about mentally disordered offenders, especially in the popular media (Link & Phelan, 2001).

The term mentally disordered offender is reductive, constructing people solely in terms of any offending behavior enacted in the context of suffering from a diagnosed mental disorder. No human being is determined by a single label, parameter, or variable. Mentally disordered offenders constitute a heterogenous not monolithic cohort. However, mentally disordered offenders are vulnerable to being stereotyped as mad, bad, dangerous, unpredictable, and violent, in spite of evidence that mental disorder does not act as a major contributory factor in criminal violence. They are also likely to be exposed to more negative attitudes than non-mentally disordered offenders (LeBel, 2008).

One of the key competencies of mental health professionals is to actively challenge the stigma to which their patients are exposed. There is evidence to suggest that the influence of the stereotypes that add to stigma can be mitigated by people having opportunities to interact with members of the stigmatized group and also through exposure to educational material (Corrigan et al., 2012). However, what can be done to address professional stigma given that professionals already interact with forensic patients and education remains an open question.

It is also important not to neglect patients' vulnerability to self-stigma and the moral injury they may experience having harmed others in the context of suffering from a mental disorder. Exposure to stigmatizing attitudes and authoritative regimes while detained in a secure setting can lead to individuals internalizing this pejorative negativity and experiencing further disempowerment and alienation as a consequence.

Discrimination and Other Forms of Injustice

Discrimination may be defined as the unfair or prejudicial treatment of different cohorts of individuals based on stigma and prejudice. When individuals receive a hospital order under s37 of the Mental Health Act (MHA) or are transferred from prison to a secure and forensic psychiatric hospital under s47 of the MHA, they face multiple uncertainties, including the nature and extent of the length of stay and associated care and treatment. Mentally disordered offenders usually experience disproportionately long imposed lengths of stay in secure hospitals clearly constitutes discrimination (Steffensen et al., 2019). The indeterminate nature of the imposition of s41 of the MHA also poses a challenge to an individual's human rights. Furthermore, given that involuntary forensic psychiatric treatment can be experienced as highly restrictive and invasive it is crucial that decision-making and practice adhere to and enact the principle of least restriction (Tomlin et al., 2018).

In comparison to general adult mental health inpatient settings, secure and forensic patients will generally experience greater levels of restriction and for longer periods of time. Longer lengths of stays necessitate a greater emphasis on protecting patients against the risk of iatrogenic harms such as institutionalization, loss of hope, stigmatization, and lack of therapeutic optimism. It is also recognized that this can place challenges in developing therapeutic relationships and that restriction can cause harm and re-traumatization (Olsson & Kristiansen, 2017).

Detention under Part III of the MHA can also entail less overt forms of coercion as individuals may feel under pressure to consent to various treatment interventions in order to eventually be discharged from the hospital. Once in the community coercion is likely to manifest in the form of the conditions of discharge such as mandatory monitoring and supervision. There is concern that there is a significant lack of proportionality between the severity of the offenses committed and subsequent sanctions including length of stay. Furthermore, given the focus on security and risk reduction within secure and forensic mental health services, policies, procedures, and practice

have the potential to compromise both the human rights and mental and physical well-being of patients.

Coercion and Restrictive Practices

The concept of coercion in the context of mental health services relates to both formal (involuntary detention, formal medication, restraint, and seclusion), informal (influencing, direction, and threat), and perceived coercion (McKeown et al., 2020). The use of formal coercion is regulated by legislation, and clinical practice guidelines and monitored by service providers (Hallett & Dickens, 2017). It refers to measures that limit patients' autonomy and freedom.

Staff may claim that restrictive interventions are necessary to maintain safety on wards (Muir-Cochrane, 2018). It has been reported that most nurses believe the use of restrictive practice and other forms of control to be unavoidable in many clinical contexts and justified both morally and therapeutically (Rose et al., 2015). In practice, such perspectives may act to legitimize and normalize coercion and associated potentially maladaptive power dynamics on wards between patients and frontline staff (Salzmann-Erikson & Eriksson, 2012).

It has been claimed that challenging conditions on wards and a culture of blame within services may predispose staff to defensive practices (McKeown et al., 2019). Similarly, any form of patient behavior which appears to be unusual or maladaptive may be interpreted as an indication of increased risk and responded to by an increase in imposed restriction. However, restrictive practices in themselves can lead to harm, for example, both physical and psycho-emotional trauma. This in turn can negatively impact relations between patients and staff and contribute to a vicious cycle of increased distress, reactive and unsafe behaviors, and further deployment of restrictive practices.

Informal coercion may manifest in complex and covert ways, for instance, as persuasion, contextual interpersonal leverage, inducement, or veiled threats such as hinting at the potential use of covert coercion if the patient does not comply (Salzmann-Erikson & Eriksson, 2012). Secure wards are highly structured environments in which patients are monitored at regular intervals; the frequency of which is dependent on perceived risk. Nurses and health care assistants act to set and maintain relational boundaries and enforce procedural security (Salzmann-Erikson & Eriksson, 2012). In such settings, both formal and informal coercion may become normalized and operationalized whenever safety concerns arise (Larsen & Terkelsen, 2014). This may be based on pretextual framings of control and coercion as being necessary to manage the potential risks posed by patients and optimize safety and order on the ward (Larsen & Terkelsen, 2014). More patient-centered approaches based on compassion and aimed at strengthening therapeutic alliances may help to mitigate the risk of closed coercive cultures developing (Price et al., 2018). It has been recognized that organizational factors such as lack of management leadership and support, policy

emphasis on security and restriction, over-burdened staff, and poor staffing levels can contribute to the development and maintenance of more closed coercive cultures (Price et al., 2018).

It is important to recognize that coercion may also occur in community forensic mental health services (often referred to as Forensic Outreach and Liaison Services). Disproportionately restrictive conditions of discharge can act as a barrier to re-integration into the community in addition to unnecessarily compromising personal autonomy, privacy, and dignity and increasing vulnerability to stigma.

There is much top-down pressure on staff to reduce the deployment of restrictive interventions alongside quality improvement work with a similar aim supported by the National Collaborative Centre for Mental Health (NCCMH, 2018). However, there are many practical barriers to improvement—understaffing and staff churn, administrative and audit demands on frontline staff, and of course the pressure from external agencies to prevent serious incidents from occurring. It is impossible for staff and services to prevent all harm and it is important that staff are supported by all levels of leadership to make grounded and evidence-based contextualized decisions which promote patient recovery, self-responsibility, and safety. In the event of harm being enacted then root cause analysis within a broader ethos of appreciative inquiry can support the identification of lessons and the embedding of proportionate learning. The reactive imposition of blanket restrictions on staff and patients can impact negatively on the quality of practice and act to increase risk. Staffing issues can result in a lack of continuity of care, relational security, and care which is not individualized. A failure to staff wards safely may also compromise the well-being of staff leading to staff burnout, increased use of blanket restrictions, and heightened and potentially unnecessary use of other restrictive practices (restraints, seclusions, and segregations), by staff who may be struggling to maintain (a sense of) control of the ward. Staff and services need to be supported to work smarter, not harder.

Epistemic, Procedural, and Occupational Injustice

Epistemic injustice has been defined as a harm done to an individual in their capacity as an epistemic subject by compromising their capacity to engage in epistemic or knowledge-based activities (Fricker, 2007). Epistemic injustice may manifest in two main ways; as testimonial injustice when the individual's capacity to contribute their knowledge is compromised, and as hermeneutical injustice when the individual's capacity to interpret and make sense of their experiences is undermined (Fricker, 2007). Mental health patients may be vulnerable to hermeneutic injustice in the context of deprivation of access to the tools with which to form their knowledge due to their mental health conditions or inpatient admission. Discriminatory judgments regarding the reliability or validity of an individual's testimony due to their mental health presentation can constitute testimonial injustice (Crichton et al., 2017). It has been claimed that the epistemic hegemony sits firmly with the clinicians and that

practitioners may be reluctant for their epistemic authority to be challenged and potentially devalued in the context of collaborative working and knowledge sharing with patients (Carel & Kidd, 2014).

A presumption of correctness of the clinical expertise and practice seems to permeate mental health legislation and practice including the operation of the First Tier Mental Health Tribunal Service in England and Wales (Markham, 2019). As doctors, forensic psychiatrists are trained to distinguish between subjective symptoms and objective signs via the deployment of diagnostic technologies and may view patient testimony as unreliable due to its anecdotal nature. This contrasts with clinical opinions which are often taken as objective facts.

Thus, there may be significant epistemic barriers to patients' experiential knowledge and learning being given due regard. Mental health stigma may manifest in clinicians leading them to view their patients as the inferior unreliable to other and their self-report and other narratives accordingly. A lack of empowerment or means for patients to assert themselves adaptively may lead patients to adopt a strategy of purposeful passivity and minimal epistemic agency, so as not to raise concerns by appearing to oppose the will and direction of the care team and thereby increase the likelihood of a shorter admission.

The psychiatric literature advises clinicians to work collaboratively with their patients, in order to develop trust and improve patient experience and compliance. It has been reported that within the clinical notes, patients are rarely constructed as saying something, rather always a perspective is applied to their words. Clinical communication is effectively controlled by the staff. Although it is recognized that clinicians should work collaboratively with patients in assessment and care planning taking into account their perspectives and experiences, in practice such sharing of knowledge formation and decision-making may be less than optimal (Stanghellini & Mancini, 2017).

Mental health professionals have the power to initiate, maintain, and propagate power and epistemic imbalances, individual mentally disordered offenders do not. In secure and forensic mental health services it is generally the Responsible Clinicians who form the dominant epistemic group and are the final and often first arbiters of the clinical and other purported truths. Implicit assumptions of unreliability and lack of insight and honesty and other threats to a person's epistemic agency can often compromise opportunities for meaningful and inclusive collaboration. Structural in addition to practice-based remedies may be required to improve the nature and degree of inter-dynamic epistemic integration between clinicians and patients.

Procedural justice pertains to the fairness and transparency of the processes by which decisions are made and enacted. Nurses and other ward staff are the monitors and enforcers of ward rules and regulations and as such exert continuous influence and regulatory control over patients detained therein (Foucault, 2000). It remains an ongoing concern of the extent to which the nursing role in ensuring conformity of the patient's body with the dictates of the hospital, may act against the development of sustained therapeutic relationships (Pieranunzi, 1997). For the patients having to

continually manifest deference to such custodians of care and order and having to request permission to access basic goods and perform the most normal of functions can deprive them of both their self-efficacy and identity (Goffman, 1961).

Patients' perceptions and experiences of what constitutes coercion may not align with those of nurses and other staff. The deployment of procedurally just ways of working has been recommended in order to mitigate against perceptions and experiences of coercion (Winick, 2008). The principles of procedural justice include transparency, fairness, respect, and validation and are in alignment with the active involvement of the patients in all aspects of their care. Coercion can cause both mental and physical harm to individuals. The experience of exposure to significant and enduring procedural injustice can alienate people from services, even if they have also at time experienced them as supportive.

It had also been recognized within commissioning and policy that patients should have daily access to opportunities for meaningful activity; social, educational, occupational, and vocational, which supports their recovery and rehabilitation. However, in reality, patients may experience privation regarding access to meaningful activity (Berzins et al., 2018). This can constitute occupational injustice; those inequitable conditions that violate the ability and opportunity of individuals to engage in meaningful occupations that contribute positively to their own well-being (Hammell, 2008). The right to participation in meaningful activity falls under the human right to well-being, yet the daily experience of many forensic patients is of activities limited to watching TV, listening to music, and smoking (American Occupational Therapy Association, 2011).

Risk Assessment and Management

It has been evidenced that clinicians perceive risk to be a core justification for inpatient detention (Bowers, 2005). In clinician-created risk narratives patients may be framed as both embodying and enacting risk; as risk entities and as dangerous and unreliable others (Coffey et al., 2017). It has also been recognized that the need for clinical intervention does not necessarily correlate with risk. However, despite the Recovery Model dominating the policy agenda in mental health for over a decade, being risk-averse is still recognized as a common characteristic of mental health nursing (Bifarin et al., 2021). The concept of risk provides the raison d'etre for the structure and operation of secure and forensic mental health services, directing every aspect of the care and treatment of mentally disordered offenders from admission to discharge and beyond. Risk assessment and management subsume all other dimensions of care and treatment. Regrettably, the existence of mentally disordered offenders has been framed as evidence of causal links between mental illness and violence or other forms of harm (Drew et al., 2016).

Reliable prediction of the behavior of mentally disordered offenders remains the perceived duty of forensic practitioners in spite of research indicating the difficulties involved in such assessments (Monahan & Steadman, 1994). A meta-analysis by Bonta and colleagues demonstrated that, both for general and violent forms of

reoffending, "Clinical or psychopathological variables were either unrelated to recidivism or negatively related" (Bonta et al., 1998). It is therefore crucial that the nature and extent to which clinical factors contribute to risk are assessed and managed in a truly individualized manner in the context of meaningful collaboration with patients (Canton, 2016). There are various risk assessment tools which have been developed to assess the risk of harm a patient might pose to others. It has been evidenced that most risk assessment tools demonstrate poor to moderate accuracy (Shepherd, 2016). The use of such measures may lead to both false positives and false negatives. Therefore, it is recommended that such tools are not used solely to assess risk or develop risk management plans (DoH, 2007/9; RCPsych, 2017).

In spite of the use of structured professional tools for risk assessment, in practice the processes of risk assessment and management can remain an unstructured and markedly heuristic, not to say off-the-cuff process, informed by anecdotes and presumptions, rather than evidence-based reasoning (Levin, 2019). Such poor practice can be more prevalent in community secure and forensic mental health settings which experience less monitoring and quality improvement oversight than the corresponding inpatient settings. Risk assessment is in practice a heuristic process relying on intuition and tacit knowledge as much as the content of patients' electronic health records; an aspect of internalized experiential learning that becomes ingrained in the practitioner's working psyche over time. Whether this involves critical thinking, reflection or reflexivity may vary at the individual practitioner level, and may markedly impact the quality of their risk assessment and management skills.

It is somewhat paradoxical that practitioners are expected to assess an individual's risk of enacting future harm in secure environment designed to prevent such behaviors (Markham, 2018). Furthermore, when detained under the MHA there is a clear incentive for patients to mask risky behaviors in order to reduce the restrictions imposed upon them and achieve discharge back into the community (Reynolds et al., 2014). It can be argued that both the above factors may act to compromise the validity of any assessment of risk conducted under such circumstances.

There has been minimal application of conceptual or causal analysis to risk assessment even in the context of consideration of dynamic factors (Ward & Fortune, 2016). The hybrid and composite nature of dynamic risk and protective factors has also been neglected potentially compromising the quality of risk assessments (Heffernan et al., 2019). To be effective, risk assessments need to identify and delineate causal risk factors and consider how they can be mitigated to inform risk management plans (Ward & Fortune, 2016). Within patient-centric risk assessment, it is crucial that all offending issues and contextual factors are identified. A key barrier to proportionate informed risk assessment can be a lack of due attention paid to protective factors in conjunction with explicit emphasis on risk and historic events (Nyman et al., 2020).

Clinicians may be disproportionately restrictive when making decisions on how to manage any potential risk a patient may present, enacting more of a custodial rather than a therapeutic role and in doing so compromise the human rights of their patients (Szmukler, 2010). Clinicians may experience the sense that their risk-averse practices,

by excluding the possibility of any risk being enacted, are thus preventative of risk, and should be embedded into their routine practice. This may lead to an increase the degree of restriction that they impose upon their patients, or at least a reluctance to be less restrictive. Such risk-averse practice can preclude valuable experiential learning, an increase in self-responsibility and recovery. Thus, the practical value and relevance of assessing long-term risk in the artificial and controlled environment of secure and forensic mental health services can be questioned (Markham, 2018).

Perceptions and understanding of risk are based primarily on experiential learning and related forms of acquired knowledge. However, clinical knowledge is prioritized over patients' experiential knowledge in many ways and contexts. Power differentials and dynamics have considerable influence on the definition, identification, assessment, and management of risk. Clinicians have the authority to construct and deploy the risks they associate with their patients (Langan, 2008). The narratives which clinicians and other staff create regarding a patient's perceived risk integrate interpretations of an individual's behavior, verbal and emotional expressions, and judgments regarding their risk-related salience. Clinicians may complete risk assessment proforma by asking the patient questions, but subsequent decisions regarding risk management and related aspects of an individual's care pathway may be made without them being involved or even aware, thus rendering them epistemically excluded (Coffey et al., 2019).

Patient Experience

"Depressingly, persons in the forensic system generally receive—if this even seems possible—less humane services than do civil patients" (Fellner, 2006). Research indicates that forensic inpatient settings are worse than the general adult mental health environments (Perlin, 2013). Not only are patient freedom, choice, and self-determination limited but the predominant expectation on patients to adhere to the rules and treatment imposed on them in a non-person-centered manner can act to increase patient dissent and lack of compliance, both overt and covert (Pouncey & Lukens, 2010). Closed cultures of practice and discourse can act to embed and propagate stigmatizing perceptions of mentally disordered offenders as inferior, unreliable, and deviant others (Berring et al., 2016).

Attempts to shift such maladaptive ways of thinking and working can be met with strong organizational resistance (McKeown et al., 2019). Furthermore, pejorative clinical stereotypes of mentally disordered offenders as lacking capacity, insight, and remorse can lead to disproportionate levels of restriction including excessively long lengths of stay in secure wards (Mezey et al., 2016). In theory, the process of recovery is structured around the principles of personal responsibility, accountability, and self-regulation. However, in practice care and treatment in secure and forensic settings remains an essentially controlled and coercive practice.

Compliance-based behavioral interventions for mentally disordered offenders are widely regarded by practitioners, services, and the wider public as necessary and

appropriate in order to treat and reduce the risks perceived to be posed acceptable by such individuals. The basic competencies and standards in nursing require that patients are treated with care and compassion but in locked secure and forensic settings nurses primarily effectively act as authoritarian enforcers of rules and regulations which may fail to differentiate between the varying degrees and forms of risk presented by their patients. It may be argued that enacting such a controlling role will impact pejoratively on nurses' perceptions of and attitudes toward their patients (Vincze et al., 2015). Patients thus remain the subjects of control in the context of what is referred to as care, and in spite of clear national policy directing the need for and benefits of more collaborative working with patients, in practice, it is the psychiatrists and the various other paid practitioners who make and enforce key decisions regarding the lives and futures of the patients.

It may be thought that the long length of stays of patients on secure wards would provide the necessary time and opportunity for practitioners to develop effective therapeutic relationships with patients, but the potential for this can be compromised by high levels of staff churn, under-recruitment to posts and over-reliance on temporary agency staff (Chandley & Rouski, 2014).

The daily reality for patients can be bleak to say the least. They may experience punitiveness via the enactment of protocols; blanket restrictions and other rigidly maintained rules and regulations. The specter of presumed public opinion and the fear of condemnation from the popular press haunts secure and forensic mental health settings and dictates and sustains this philosophy of stigmatization and oppression. Patients have reported experiencing negative staff attitudes and neglect, as punitive and disempowering. Patients have identified staff shortages as an additional source of restriction, lack of meaningful activity, and disempowerment (Livingston, 2018). Having to request access to the basic materials of daily living including an individual's own private possessions from locked security cupboards can impact negatively on their sense of agency, self-worth, and dignity. Such power imbalances can lead to distorted and ultimately maladaptive relationships. For instance, in spite of policy and funding initiatives directing the embedding of collaborative risk assessment and management in secure and forensic services staff patient relationship remain characterized by mutual distrust with the significant power disparities acting against meaningful collaboration and epistemic exchange (Mann et al., 2014, Markham, 2019).

The culture in a secure and forensic setting can be epistemically restrictive, not to say oppressive. Authoritarian and custodial practices dominate secure and forensic mental health services and can often act in direct opposition to more recovery-focused and person-centered ways of working. Clinicians and managers may claim to know what is best for the patients and have their interests at heart, but reports of patient experience of staff and the care they receive within such services imply otherwise (O'Dowd et al., 2022). Aware that their privileges and progression to less restrictive settings are conditioned on their perceived risk, patients may engage in overtly compliant behaviors and desist from expressing their true attitudes and feelings in order to manipulate staff impressions (Shingler et al., 2020). Patients have reported perceiving the need to

mask any anger or other negative emotions they may experience lest staff interpret such presentations as an indication of risk (Reynolds et al., 2014). Similarly, in the context of decisional control belonging predominantly to staff, patients may deliberately adopt a strategy of subservient passivity in order to obtain privileges such as a greater degree of leave and reduce their length of stay (Reynolds et al., 2014). Thus, the predominance of perceived risk as the arbiter of patient progression may lead to risk and related clinical needs being masked and serve to enhance rather than mitigate risk (Markham, 2018).

Patients who have reached a stage in their recovery where they deploy their experiential knowledge of how to navigate the secure and forensic mental health system can provide significant support to the less experienced patients. Such grassroots peer support can help patients develop a better sense of themselves and others (Maruna, 2001). The imperative to survive and if possible, progress within these multiple and intertwined forms of disempowerment may lead to patients deploying the dominant epistemologies in order to get their basic human and recovery needs met. In this manner, patients may regain a sense of power and control and ultimately safety.

Stigmatization and Human Rights

Human Rights Challenges in Secure and Forensic Mental Health Services

The Human Rights Act (1998) has brought 16 protections from the European Convention on Human Rights into U.K. legislation. The European Court of Human Rights (ECtHR) has an established position in setting standards of human rights, including those of people detained against their will under mental health legislation (Richardson, 2005). However, it has also been claimed that these standards are not necessarily put into practice, and furthermore, that mental health legislation can act to stigmatize and discriminate against those with mental health conditions (WHO, 2022).

Mentally disordered offenders find themselves positioned at the interface of the criminal justice and mental health systems. The mental health system and associated agencies and society in general harbor significant prejudices and discrimination against people with mental health conditions who commit criminal offenses. It has been recognized that there is a need for legislation to prevent discrimination against persons who experience mental health conditions (WHO, 2005). Cases regarding Article 5, the right to liberty, have been brought by forensic psychiatric patients to the ECtHR, in the context of the indefinite periods of detentions which can be imposed upon mentally disordered offenders (Hare Duke et al., 2018). The WHO advises that any period of detention should be no longer than that of the corresponding criminal justice sentence, and that alternative disposals such as non-custodial provisions and restorative justice should be considered (WHO, 2005, 2022). Concerns have also arisen regarding breaches to the right to freedom from cruel, inhuman, and degrading treatment (Article 3), and to private and family life (Article 8). This is due to decisional control regarding involuntary treatment and other aspects of a mentally

disordered offender's life being held by psychiatric practitioners when they are detained under mental health legislation, and also the imposition of enhanced levels of observation and other forms of monitoring and segregation. Furthermore, in England and Wales, multiple concerns have been raised regarding the fairness and transparency of the First Tier Mental Health Tribunal Service via which forensic patients can appeal against continued detention under the MHA (1983; Markham, 2019).

Forensic psychiatric services have long been associated with the informal evolution of closed and potentially toxic cultures and significant human rights violations. A recent example of this is the case of the Greater Manchester Mental Health Trust's (GMMH), the Edenfield Centre, a medium secure unit featured in a BBC Panorama documentary in September 2022 following an undercover investigation. The program featured footage and both patient and staff testimony of patients being subjected to verbal and physical abuse. Following being informed by BBC Panorama of significant patient failings and patient harm, NHS England North West put in place a Rapid Quality Review process to prioritize support and take immediate actions to improve patient safety. Patients were moved to other services and in some cases readmitted to prison. NHS England subsequently commissioned a fuller independent review of the GMMH Adult Forensic Services which reported its findings to NHS England in October 2023.

It is of concern that there has been a noticeable lack of human rights activism for forensic patients both nationally and internationally. The plight of forensic patients has received similar disregard within the academic literature and legislative case law (Ward & Birdgen, 2007). Even the celebrated Convention on the Rights of People with Disabilities (CRPD) did not deign to mention the precarity and vulnerability of mentally disordered. Furthermore, little attention was paid to the human rights of mentally disordered offenders during the discourse and transaction that preceded and led to the formulation of the CRPD (Perlin, 2016). However, the WHO has acknowledged that mentally disordered offenders are a stigmatized cohort who can be subject to discrimination from various agencies leading to increased precarity and vulnerability to abuse (WHO, 2010).

Therapeutic Jurisprudence

Therapeutic jurisprudence concerns integrated consequentialist, deontological, and rights-based approaches to deployment of legislation (Kress, 1999). It considers whether legal systems and processes can be reformulated to augment their therapeutic value while maintaining alignment with the principles of due process and emphasizes the need and value in considering the actual impact of legal judgments and other decisions on the regulation of individual's actions especially those who are most marginalized and subject to stigma and other forms of discrimination (Perlin & Cucolo, 2016). Therapeutic jurisprudence thereby seeks to promote the upholding of human rights and the ethics (Daicoff &Wexler, 2003). It has been argued that human rights can provide an evaluative basis for the development and application of therapeutic

jurisprudence and that this may be more effective in the long term than alternative approaches (Birgden & Perlin, 2009). Within this, it must be remembered that the law's use of mental health information to improve therapeutic functioning cannot impinge upon justice concerns (Wexler, 1993). However, it is recognized that although the principal purpose of the judicial system is to seek truth and justice, this is not necessarily in conflict with destigmatizing and therapeutically oriented goals.

It is important to recognize the significant potential for therapeutic jurisprudence to support the application of destigmatizing and rights-based practice in the context of promoting the use of the law to maximize therapeutic consequences and minimize stigmatizing anti-therapeutic impacts (Winick, 2006). Treating individuals including prisoners with respect and humanity is recognized to enhance compliance and therefore public safety (Birgden, 2009). Therapeutic jurisprudence also seeks to reduce power imbalances and their effects on vulnerable offenders (Frailing & Perlin, 2020).

Means of Remediation and Restoration

Human Rights

Secure and forensic mental health services are mandated as duty-bearers to uphold the human rights of their patients (Human Rights Act 1998). It would be reasonable to assume that an authentically human rights-based approach to the care and treatment of mentally disordered offenders might offset any qualification of their liberty which might be required to maintain both their safety and that of others. Rights-based care which respects the dignity and optimizes the autonomy of forensic patients has the potential to be experienced as fairer and more legitimate, thus leading to more adaptive ways of working, therapeutical alliances, and recovery outcomes including successful re-integration into the society.

Therapeutic Security

Therapeutic security conceptualizes safety and security as being essential to the therapeutic process (Warburton & Stahl, 2020). According to the Trinitarian model of therapeutic security, there are three key aspects of safety in secure environments; physical, relational, and procedural security (Crichton, 2009). Physical security concerns the security and safety of the built environment, procedural security; the operation and processes within the organization and relational security; patient-to-staff ratios, patient risk assessment and management therapeutic relationships, interventions, treatment, and activities (Kennedy, 2022). Relational Security thus considers the different but interconnected identities that exist, interact, and influence the safety on the ward. In this context, it is important that in practice staff are aware of the stigma associated with the mentally disordered offender identity and are sensitive to and therapeutically responsive to patients' self-stigma and their own biases and stigmatizing beliefs, attitudes, and behaviors, together with those of the wider system. Ward staff may be able to recognize

the development of maladaptive relational dynamics and behaviors within the patient cohort such as bullying, subjugation, and illicit trading of possessions and gifts from family and friends, and protect the more vulnerable and submissive patients. Such subcultures can impact both inter and intra-patient dynamics and hence relational security. What is most important in terms of need and impact is consistent commitment within all levels of services and by all members of staff to focus on, implement, enact, and learn from more relational and collaborative approaches to assessment, treatment, and of course, assessment and risk management. However, relational approaches have an intangibility about them that can lead policy makers, commissioners, and clinicians to fall back on more tangible physical and procedural and potentially stigmatizing approaches.

Therapeutic Relationships

Within mental health services, significant emphasis is placed on the completion of record-taking and other administrative tasks, such as routine ward-based audits. Patients may perceive and experience nurses primarily as the organizers rather than the deliverers of care (Hurley & Lakeman, 2021). Nurses and nursing strategies and practices may place more emphasis on the use of routine observations than on active engagement to monitor and assess risk, however, as passive observers detached from the individual and their inner experiences, the observations may lead to only partial and potentially biased knowledge and awareness. It is also recognized that difficulties in recruiting and retaining nurses and the consequent human churn and inadequate staffing levels on wards can compromise both the continuity of care and the existence and quality of non-stigmatizing therapeutic relationships. This in turn may lead to reduced relational security and increased reliance on blanket restrictions and other restrictive practices and interventions on wards all of which may impact negatively patients' psycho-emotional and physical safety, including self-stigma (Berzins et al., 2018).

Forensic staff often have to routinely administer involuntary care and implement restrictions. This can lead to challenging tensions arising between patients and the corresponding members of staff, hence the need to invest in the development of robust and adaptive therapeutic relationships (McAndrew et al., 2014). What may often be ignored is that patients may have their own survival-driven risk assessment processes "ingrained" in their psyches, regarding the physical and relational safety of the ward environment at any given moment in time and the likelihood of them being able to get their basic and other needs met. There may present relational obstacles to the open sharing of the personal risk and related experiences. This emphasizes the need for staff to have the time, ability, and motivation to develop adaptive and mutually respectful and trusting therapeutic relationships with patients (Deering et al., 2019).

Collaborative Risk Assessment and Management Planning

Collaborative risk assessment and management involves individual patients and the clinical team, including family members when desired by the patient, to work together

to better understand the individual's potential risks and develop management plans to mitigate these risks and support safety and recovery. The value of and need for collaborative risk assessment and management planning have been recognized in mental health policy and related literature for over a decade (DoH, 2007/9; Söderberg et al., 2020). Best Practice in Managing Risk (DoH, 2007/9) stated that patients should be involved in assessing risk and the decision-making regarding risk management. It also emphasized the potential positive effects on progress of recovery of such involvement. This has been reflected in mental health commissioning and in 2014/15 and 2015/16, there were two Commissioning for Quality and Innovation schemes requiring medium and low-secure mental health services to deliver joint training for staff and patients regarding risk assessment and provide evidence of patient involvement in their risk assessment. However, there are indications that there may be gaps between policy and practice regarding collaborative risk assessment and management within services. For instance, there is little evidence to suggest that this leads to the embedding of collaborative risk assessment throughout services (Markham, 2020). Recent research indicates that collaborative risk assessment is yet to become the norm in secure and forensic practice and that patients may still remain ignorant of the process and content of assessments of their risk or that involvement may be an essentially passive process in which patients can at best hope to have their views solicited of their risk assessment after it has been completed by staff without their input (Nyman et al., 2020).

The National Institute of Health and Care Excellence (NICE guidelines regarding the risk management of violence and aggression stipulate that patients should be involved in all decisions regarding their care and treatment with a focus on joint formulation of care and risk management plans (NICE, 2015). The Royal College of Psychiatrists states that psychiatrists have a responsibility to involve their patients in risk management and places emphasis on the value of patient insight in identifying their vulnerabilities regarding risk (RCPsych, 2017). Furthermore, it has been recommended that the risk assessment includes the patient's account and explanation of their risk (RCPsych, 2017) together with an integrated formulation of their strengths and recovery capital within the risk management plans (DoH, 2007/9).

Paternalism and other authoritative barriers need to be overcome if collaborative working is to become embedded in practice (Völlm et al., 2017). There may be significant epistemic barriers to patients' experiential knowledge and learning being given due regard. Mental health stigma may manifest in clinicians leading them to view their patients as the inferior unreliable to other and their self-report and other narratives accordingly. A lack of empowerment or means for patients to assert themselves adaptively may lead patients to adopt a strategy of purposeful passivity so as not to raise concerns by appearing to oppose the will and direction of the care team and thereby increase the likelihood of a shorter admission. In contrast from an epistemic perspective collaborative risk assessment can reify patients' views and insights into their understanding of and experience of their risk and thereby allow them to contribute knowledge of that which clinicians may be unaware (Ray & Simpson, 2019).

It has been claimed that a positive therapeutic alliance is crucial in managing complex discussion regarding risk and restrictions (Nyman et al., 2020). The relational nature of collaborative risk assessment can also serve to strengthen therapeutic alliances, mitigate stigma, and enhance understanding of which risk management interventions are needed and why (Kumar & Simpson, 2005). Ultimately such collaboration may support patients to take greater responsibility for their own well-being and actions (Kroner, 2012). In spite of this patient collaboration does not always occur in practice regardless of the acknowledged risk that by excluding patient's knowledge and understanding pertinent risk information may be missed (Nyman et al., 2020). Furthermore, not involving patients in their risk assessment and management decisions may foster distrust and resentment and impact negatively in engagement.

The view that patients are able to make a positive contribution to their risk assessment is based on the belief that patients having sole access to their own internal states; thoughts, feelings, motivation, and intents possess unique insights into their propensity for future risk (Kroner, 2012). Furthermore, patients have been evidenced to be able to engage and contribute sensitive self-information to inform risk assessment and planning (Peterson et al., 2011). There is concern that risk assessment tools may not always capture factors which are relevant to an individual patient's risk and may therefore lack content validity (Connell et al., 2018). This emphasizes the need for patients to be involved in the future development of risk assessment tools. However, this may be irrelevant in the context of evidence that staff may fail to act in accordance with formal risk assessment procedures and base assessments and management on their intuitions, leaving the process open to contamination by both conscious and subconscious forms of human bias, including stigma-based stereotypes (Levin et al., 2018).

Patients need to have access to the clinician-authored risk narratives and be involved in assessment to challenge any inaccuracies and other biases (Coffey et al., 2019). However, the open sharing of risk-related information may also be problematic for patients who may fear they may as a consequence be perceived as posing a greater risk than previously thought. However, collaborative risk assessment can also act to increase and broaden patients' understanding of the potential value of targeted therapeutic interventions and encourage them to take more responsibility for their actions (Kroner, 2012). The partnership working that is the hallmark of good collaboration may also act to increase patients' self-esteem and self-efficacy in addition to augmenting therapeutic alliances, and thereby reduce self-stigma (Dixon, 2012).

Conclusion

Human rights-based, destigmatizing, and non-discriminatory praxis and practice in forensic mental health services necessitates a person-centered approach which takes into account the lived and living experiences of those who come into contact with the criminal justice system in the context of experiencing mental health conditions. To counter stigmatization and discrimination, the public stereotype of people with

mental health conditions as being the alien, inferior and innately unreliable and potentially dangerous other needs to be robustly challenged through all available means. The need for this is further enhanced by the potential for societal perceptions of disordered offenders to influence the nature and extent of the regard given to the human rights of forensic patients by the state, and the legal system including appeals against continuing detention presented to the First Tier Mental Health Tribunal Process. The transparency of secure and forensic mental health services and related agencies especially the Mental Health Tribunal System and the Ministry of Justice, in terms of policies and processes relating to mentally disordered offenders, is crucial for the upholding of human rights and destigmatization to be effectively monitored and assured.

Clinical interactions should serve as opportunities for meaningful communication and mutual learning. However, in risk assessment and other contexts, the testimony and interpretive skills of mentally disordered offenders may be questioned or dismissed due to biased assumptions of unreliability and duplicity frequently attributed to mentally disordered offenders. Collaborative risk assessment and management planning requires patients, their clinical teams, and where relevant their families and carers to work together to understand the patient's risks and develop a mutually agreed care plan to optimize safety and recovery. This aligns with the aspirations of the NHS Long Term Plan, which seeks to make personalized care "business as usual."

A number of clinical and risk-oriented epistemologies manifest within the relational structure of the ward based on patients' experiential knowledge of mental health conditions and associated services, and the taught and practice-based experiential knowledge of staff members. The various epistemologies may not be valued in an equitable manner. Patients may experience testimonial injustice wherein staff knowledge and perspectives carry more weight and prominence both in decision-making and various other narratives and discourses including the electronic patient record, reports, and tribunal processes. Furthermore, patients may lack the hermeneutic resources to make optimal use of their experiential knowledge due to educational privation and other disparities. This can lead to further epistemic injustice, marginalization, and stigma. Within risk assessment and management, there is a real need to motivate practitioners to respond to uncertainty and perceived risk in a positive manner that empowers patients to take more responsibility for their own actions and recovery. Indeed, it has been acknowledged in policy and practice documentation that empowerment of patients may counteract the disadvantages and stigmatization associated with the current clinical decisional hegemony.

In the context of ongoing risk assessment and management and re-integration into the community, it is essential that patients receive support from forensic social practitioners, especially with regard to countering disproportionate risk aversion, mental health stigma and the various myths regarding mentally ill individuals who have been in contact with the criminal justice system. Community patients, especially those under an S41 MHA restriction order may need enhanced support, especially with regard to disclosure upon entry into education, training, and employment to minimize the risk of stigmatization and further marginalization. Forensic patients are

probably the ones who are most in need of practitioners' expertise in rights-based practice and the ability to challenge the various barriers to socialization they may face. It is understandable that practitioners working with mentally disordered offenders may experience anxieties about the risks to self and others, but the professional rewards of being able to tolerate such anxieties and continue to champion their patients' interests far outweigh the risks associated with rare and humanly unpredictable events.

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References

American Occupational Therapy Association. (2011). The philosophical base of occupational therapy. *American Journal of Occupational Therapy*, *65*(6_Suppl), Article S65.

Berring, L. L., Pedersen, L., & Buus, N. (2016). Coping with violence in mental health care settings: Patient and staff member perspectives on de-escalation practices. *Archives of Psychiatric Nursing*, *30*(5), 499–507.

Berzins, K., Louch, G., Brown, M., O'Hara, J. K., & Baker, J. (2018). Service user and carer involvement in mental health care safety: Raising concerns and improving the safety of services. *BMC Health Services Research*, *18*(1), 644.

Bifarin, O., Felton, A., & Prince, Z. (2021). Defensive practices in mental health nursing: Professionalism and poignant tensions. *International Journal of Mental Health Nursing*, *31*(3), 743–751.

Birgden, A. (2009). Therapeutic jurisprudence and offender rights: A normative stance is required. *Law Review of the University of Puerto Rico*, *78*(1), 43–60.

Birgden, A., & Perlin, M. L. (2009). "Where the home in the valley meets the damp dirty prison": A human rights perspective on therapeutic jurisprudence and the role of forensic psychologists in correctional settings. *Aggression & Violent Behavior*, *14*(4), 256–263.

Bonta, J., Law, M., & Hanson, K. (1998). The prediction of criminal and violent recidivism among mentally disordered offenders: A meta-analysis. *Psychological Bulletin*, *123*(2), 123–142.

Bowers, L. (2005). Reasons for admission and their implications for the nature of acute inpatient psychiatric nursing. *Journal of Psychiatric and Mental Health Nursing*, *12*(2), 231–236.

Canton, R. (2016). Troublesome offenders, undeserving patients: The precarious rights of mentally disordered offenders. In J Winstone (Ed.), *Mental health, crime and criminal justice: Responses and reforms* (pp. 28–47). Palgrave Macmillan. https://doi.org/10.1057/9781137453884_3

Carel, H., & Kidd, I. J. (2014). Epistemic injustice in healthcare: A philosophical analysis. *Medical Health Care Philosophy*, *17*(4), 529–540.

Chandley, M., & Rouski, M. (2014). Recovery, turning points and forensics: Views from the ward in an English high secure facility. *Mental Health and Social Inclusion*, *18*(2), 83–91.

Coffey, M., Cohen, R., Faulkner, A., Hannigan, B., Simpson, A., & Barlow, S. (2017). Ordinary risks and accepted fictions: How contrasting and competing priorities work in risk assessment and mental health care planning. *Health Expectations*, *20*(3), 471–483.

Coffey, M., Hannigan, B., Barlow, S., Cartwright, M., Cohen, R., Faulkner, A., Jones, A., & Simpson, A. (2019). Recovery-focussed mental health care planning and coordination in acute inpatient mental health settings: A cross national comparative mixed methods study. *BMC Psychiatry*, *19*(1), Article 115.

Connell, J., Carlton, J., Grundy, A., Taylor-Buck, E. A., Keetharuth, A. D., Ricketts, T., Barkham, M., Robotham, D., Rose, D., & Brazier, J. (2018). The importance of content and face validity in instrument development: Lessons learnt from service users when developing the recovering quality of life measure (ReQoL). *Quality of Life Research*, *27*(7), 1893–1902.

Corrigan, P. W., Morris, S. B., Michaels, P. J., Rafacz, J. D., & Rüsch, N. (2012). Challenging the public stigma of mental illness: A meta-analysis of outcome studies. *Psychiatric Services*, *63*(10), 963–973.

Corrigan, P. W., & O'Shaughnessy, J. R. (2007). Changing mental illness stigma as it exists in the real world. *Australian Psychologist*, *42*(2), 90–97.

Crichton, J. (2009). Defining high, medium, and low security in forensic mental healthcare: The development of the matrix of security in Scotland. *Journal of Forensic Psychiatry and Psychology*, *20*(3), 333–353.

Crichton, P., Carel, H., & Kidd, I. J. (2017). Epistemic injustice in psychiatry. *BJPsych Bulletin*, *41*(2), 65–70.

Daicoff, S., & Wexler, D. B. (2003). Therapeutic jurisprudence. In A. M. Goldstein (Ed.), *Handbook of psychology: Forensic psychology* (Vol. 11, pp. 561–580). John Wiley & Sons, Inc.

Deering, K., Pawson, C., Summer, N., & Williams, J. (2019). Patient perspectives of helpful risk management practices within mental health services. A mixed studies systematic review of primary research. *Journal of Psychiatric and Mental Health Nursing*, *26*(5-6), 185–197.

Dixon, J. (2012). Mentally disordered offenders' views of 'their' risk assessment and management plans: Perceptions of health risks. *Health, Risk & Society*, *14*(7-8), 667–680.

DoH. (2007/9). *Best practice in managing risk: Principles and evidence for best practice in the assessment and management of risk to self and others in mental health services*. Department of Health.

Drew, A., Kingston, M., Olver, E., Harris, M., Booth, B. D., Gulati, S., & Cameron, C. (2016). The relationship between mental illness and violence in a mentally disordered offender sample: Evaluating criminogenic and psychopathological predictors. *Psychology, Crime & Law*, *22*(7), 678–700.

Fellner, J. (2006). A corrections quandary: Mental illness and prison rules. *Harvard Civil Rights-Civil Liberties Law Review*, *41*(2), 391–412.

Foucault, M. (2000). Madness and society. In J. D. Faubion (Ed.), *Aesthetics: Essential works of Foucault, 1954–1984* (Vol. 2, pp. 335–342). Penguin Books.

Fox, A. B., Earnshaw, V. A., Taverna, E. C., & Vogt, D. (2018). Conceptualizing and measuring mental illness stigma: The mental illness stigma framework and critical review of measures. *Stigma and Health*, *3*(4), 348–376.

Frailing, K., & Perlin, M. L. (2020). Introduction to therapeutic jurisprudence and nonjudicial decision making. *American Behavioral Scientist*, *64*(12), 1683–1685.

Fricker, M. (2007). *Epistemic injustice: Power and the ethics of knowing*. Oxford University Press.

Goffman, I. (1961). *Asylums: Essays on the social situation of mental patients and other inmates*. Doubleday (Anchor).

Hallett, N., & Dickens, G. L. (2017). De-escalation of aggressive behaviour in healthcare settings: Concept analysis. *International Journal of Nursing Studies*, *75*(5), 10–20.

Hammell, K. W. (2008). Reflections on…well-being and occupational rights. *Canadian Journal of Occupational Therapy*, *75*(1), 61–64.

Hare Duke, L., Furtado, V., Guo, B., & Völlm, B. A. (2018). Long-stay in forensic-psychiatric care in the UK. *Social Psychiatry and Psychiatric Epidemiology*, *53*(3), 313–321.

Heffernan, R., Wegerhoff, D., & Ward, T. (2019). Dynamic risk factors: Conceptualization, measurement, and evidence. *Aggression and Violent Behavior*, *48*(4), 6–16.

Horsfall, J., Cleary, M., & Hunt, G. (2010). Stigma in mental health: Clients and professionals. *Issues in Mental Health Nursing*, *31*(7), 450–455.

Hurley, J., & Lakeman, R. (2021). Making the case for clinical mental health nurses to break their silence on the healing they create: A critical discussion. *International Journal of Mental Health Nursing*, *30*(2), 574–582.

Kennedy, H. (2022). Models of care in forensic psychiatry. *BJPsych Advances*, *28*(1), 46–59.

Kress, K. (1999). Therapeutic jurisprudence and the resolution of value conflicts: What we can realistically expect, in practice, from theory. *Behavioral Sciences & the Law*, *17*(5), 555–588.

Kroner, D. G. (2012). Service user involvement in risk assessment and management: The transition inventory. *Criminal Behaviour and Mental Health*, *22*(2), 136–147. https://doi.org/10.1002/cbm.1825

Kumar, S., & Simpson, A. (2005). Application of risk assessment for violence methods to general adult psychiatry: A selective literature review. *Australian and New Zealand Journal of Psychiatry*, *39*(5), 328–335.

Langan, J. (2008). Involving mental health service users considered to pose a risk to other people in risk assessment. *Journal of Mental Health*, *17*(5), 471–481.

Larsen, I. B., & Terkelsen, T. B. (2014). Coercion in a locked psychiatric ward. *Nursing Ethics*, *21*(4), 426–436.

LeBel, T. P. (2008). Perceptions of and responses to stigma. *Sociology Compass*, *1*(2), 409–432.

Levin, S. (2019). *The challenges of using structured risk assessment instruments in forensic psychiatric care* [Unpublished doctoral dissertation]. Linköping University.

Levin, S. K., Nilsen, P., Bendtsen, P., & Bülow, P. (2018). Staff perceptions of facilitators and barriers to the use of a short-term risk assessment instrument in forensic psychiatry. *Journal of Forensic Psychology Research and Practice*, *18*(3), 199–228.

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology*, *27*(1), 363–385.

Livingston, J. D. (2018). What does success look like in the forensic mental health system? Perspectives of service users and service providers. *International Journal of Offender Therapy and Comparative Criminology*, *62*(1), 208–228.

Livingston, J. D., Milne, T., Fang, M. L., & Amari, E. (2012). The effectiveness of interventions for reducing stigma related to substance use disorders: A systematic review. *Addiction*, *107*(1), 39–50.

Mann, B., Matias, E., & Allen, J. (2014). Recovery in forensic services: Facing the challenge. *Advances in Psychiatric Treatment*, *20*(2), 125–131.

Markham, S. (2018). Red-teaming the panopticon (mobilising adaptive change in secure and forensic settings). *The Journal of Forensic Psychiatry & Psychology*, *29*(1), 16–36.

Markham, S. (2019). First-tier tribunals for mental health in England: Are they fit for purpose? *The Lancet Psychiatry*, *7*(3), 226–227.

Markham, S. (2020). Collaborative risk assessment in secure and forensic mental health settings in the UK. *General Psychiatry*, *33*(5), Article e100291.

Maruna, S. (2001). *Making good: How ex-convicts reform and rebuild their lives*. American Psychological Association Books.

McAndrew, S., Chambers, M., Nolan, F., Thomas, B., & Watts, P. (2014). Measuring therapeutic engagement. *International Journal of Mental Health Nursing*, *23*(3), 212–220.

McKeown, M., Scholes, A., Jones, F., & Aindow, W. (2019). Coercive practices in mental health services: Stories of recalcitrance, resistance, and legitimation. In A. Daley, P. Beresford, & L. Costa (Eds.), *Madness, violence, and power: A critical collection* (pp. 263–285). University of Toronto Press.

McKeown, M., Thomson, G., Scholes, A., Jones, F., Downe, S., Price, O., Baker, J., Greenwood, P., Whittington, R., & Duxbury, J. (2020). Restraint minimisation in mental health care: Legitimate or illegitimate force? An ethnographic study. *Sociology of Health & Illness*, *42*(3), 449–464.

Mezey, G., Youngman, H., Kretzschmar, I., & White, S. (2016). Stigma and discrimination in mentally disordered offender patients–a comparison with a non-forensic population. *The Journal of Forensic Psychiatry & Psychology*, *27*(4), 517–529.

Monahan, J., & Steadman, H. J. (Eds.). (1994). *Violence and mental disorder: Developments in risk assessment*. The University of Chicago Press.

Muir-Cochrane, E. (2018). On restrictive practices: Care and culture. *Journal of Psychiatric and Mental Health Nursing*, *27*(5), 451–452.

NCCMH. (2018). MH-SIP – Reducing restrictive practice (RRP). https://www.rcpsych.ac.uk/improving-care/nccmh/quality-improvement-programmes/MHSIP-reducing-restrictive-practice

NICE. (2015). *Violence and aggression: Short-term management in mental health, health and community settings*. National Institute for Health and Care Excellence.

Nyman, M., Hofvander, B., Nilsson, T., & Wijk, H. (2020). Mental health nurses' experiences of risk assessments for care planning in forensic psychiatry. *International Journal of Forensic Mental Health*, *19*(2), 103–113.

O'Dowd, R., Laithwaite, H., & Quayle, E. (2022). A qualitative exploration of service users' experiences of violence risk assessment and management in forensic mental health settings: An interpretative phenomenological analysis. *Journal of Forensic Psychology Research and Practice*, *22*(4), 357–388.

Olsson, H., & Kristiansen, L. (2017). Violence risk assessment in forensic nurses' clinical practice: A qualitative interview study. *Global Journal of Health Science*, *9*(12), Article 56.

Perlin, M. (2013). *A prescription for dignity: Rethinking criminal justice and mental disability law*. Routledge.

Perlin, M. (2016). International human rights and institutional forensic psychiatry: The core issues. In B. Vollm, & N. Nedopil (Eds.), *The use of coercive measures in forensic psychiatric care: Legal, ethical and practical challenges* (pp. 9–29). Springer.

Perlin, M., & Cucolo, H. (2016). *Mental disability law: Civil and criminal* (3rd ed.). LexisNexis.

Peterson, J., Skeem, J., & Manchak, S. (2011). If you want to know, consider asking: How likely is it that patients will hurt themselves in the future? *Psychological Assessment*, *23*(3), 626–634.

Pieranunzi, V. (1997). The lived experience of power and powerlessness in psychiatric nursing: A Heideggerian hermeneutical analysis. *Archives of Psychiatric Nursing*, *11*(3), 155–162.

Pouncey, C. L., & Lukens, J. M. (2010). Madness versus badness: The ethical tension between the recovery movement and forensic psychiatry. *Theoretical Medicine and Bioethics*, *31*(1), 93–105.

Price, O., Baker, J., Bee, P., Grundy, A., Scott, A., Butler, D., Cree, L., & Lovell, K. (2018). Patient perspectives on barriers and enablers to the use and effectiveness of de-escalation techniques for the management of violence and aggression in mental health settings. *Journal of Advanced Nursing*, *74*(3), 614–625.

Ray, I., & Simpson, A. I. (2019). Shared risk formulation in forensic psychiatry. *The Journal of the American Academy of Psychiatry and the Law*, *47*(1), 22–28.

RCPsych. (2017). *Rethinking risk to others in mental health services*. Royal College of Psychiatrists.

Reynolds, L. M., Jones, J. C., Davies, J. P., Freeth, D., & Heyman, B. (2014). Playing the game: Service users' management of risk status in a UK medium secure forensic mental health service. *Health, Risk & Society*, *16*(3), 199–209.

Richardson, G. (2005). The European convention and mental health law in England and Wales: Moving beyond process? *International Journal of Law and Psychiatry*, *28*(2), 127–139.

Rose, D., Evans, J., Laker, C., & Wykes, T. (2015). Life in acute mental health settings: Experiences and perceptions of service users and nurses. *Epidemiology and Psychiatric Sciences*, *24*(1), 90–96.

Salzmann-Erikson, M., & Eriksson, H. (2012). Panoptic power and mental health nursing–space and surveillance in relation to staff, patients, and neutral places. *Issues in Mental Health Nursing*, *33*(8), 500–504.

Shepherd, S. M. (2016). Violence risk instruments may be culturally unsafe for use with indigenous patients. *Australasian Psychiatry*, *24*(6), 565–567.

Shingler, J., Sonnenberg, S. J., & Needs, A. (2020). Psychologists as 'the quiet ones with the power': Understanding indeterminate sentenced prisoners' experiences of psychological risk assessment in the United Kingdom. *Psychology, Crime & Law*, *26*(4), 571–592.

Söderberg, A., Wallinius, M., & Hörberg, U. (2020). An interview study of professional carers' experiences of supporting patient participation in a maximum security forensic psychiatric setting. *Issues in Mental Health Nursing*, *41*(3), 201–210.

Stanghellini, G., & Milena, M. (2017). *The therapeutic interview in mental health: A values-based and person-centered approach*. Cambridge University Press.

Steffensen, T., Gaardsted Frandsen, M., & Nielsen, N. (2019). *Forensic psychiatry. In a human rights perspective*. The Danish Institute for Human Rights. https://menneskeret.dk/udgivelser/retspsykiatri-menneskeretligt-perspektiv

Szmukler, G. (2010). PS01-02—Ethical issues related to coercive measures in psychiatry. *European Psychiatry*, *25*(S1), 25–71.

Tomlin, J., Bartlett, P., & Völlm, B. (2018). Experiences of restrictiveness in forensic psychiatric care: Systematic review and concept analysis. *International Journal of Law and Psychiatry*, *57*(1), 31–41.

Vincze, M., Fredriksson, L., & Wiklund Gustin, L. (2015). Nurses' understanding of suffering. *International Journal of Mental Health Nursing*, *24*(2), 149–157.

Völlm, B., Foster, S., Bates, P., & Huband, N. (2017). How best to engage users of forensic services in research: Literature review and recommendations. *International Journal of Forensic Mental Health*, *16*(2), 183–195.

Warburton, K., & Stahl, S. M. (2020). Balancing the pendulum: Rethinking the role of institutionalization in the treatment of serious mental illness. *CNS Spectrums*, *25*(1), 115–118.

Ward, T., & Birgden, A. (2007). Human rights and correctional clinical practice. *Aggression and Violent Behavior*, *12*(6), 628–643.

Ward, T., & Fortune, C. A. (2016). From dynamic risk factors to causal processes: A methodological framework. *Psychology, Crime & Law*, *22*(1-2), 190–202.

Wexler, D. B. (1993). Therapeutic jurisprudence and changing concepts of legal scholarship. *Behavioral Sciences and the Law*, *11*(1), 17–21.

WHO. (2005). Human Rights Act. Retrieved February 19, 2023, from https://www.equalityhumanrights.com/en/human-rights/human-rights-act

Winick, B. J. (2006). Therapeutic jurisprudence: Enhancing the relationship between law and psychology. *Law and Psychology: Current Legal Issues*, *9*(1), 30–48. https://ssrn.com/abstract=985088

Winick, B. J. (2008). A therapeutic jurisprudence approach to dealing with coercion in the mental health system. *Psychiatry, Psychology and Law*, *15*(1), 25–39. https://ssrn.com/abstract=1157510

World Health Organization. (2010). *Mental health and development: Targeting people with mental health conditions as a vulnerable group*. Retrieved February 19, 2023, from https://ssrn.com/abstract=2412550

World Health Organization. (2022). *World mental health report: Transforming mental health for all*. Retrieved February 19, 2023, from https://www.who.int/publications/i/item/9789240049338

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