

**‘Insight into offending behaviour’: how professionals
define, use and assess the construct in the risk
assessment of mentally disordered offenders.**

Zenobia Amy Storah

**D.Clin.Psy. thesis (Volume 1), 2007
University College London**

UMI Number: U593457

All rights reserved

INFORMATION TO ALL USERS

The quality of this reproduction is dependent upon the quality of the copy submitted.

In the unlikely event that the author did not send a complete manuscript and there are missing pages, these will be noted. Also, if material had to be removed, a note will indicate the deletion.



UMI U593457

Published by ProQuest LLC 2013. Copyright in the Dissertation held by the Author.
Microform Edition © ProQuest LLC.

All rights reserved. This work is protected against
unauthorized copying under Title 17, United States Code.



ProQuest LLC
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106-1346

Overview

This thesis describes research investigating the psychological construct of 'insight into offending behaviour' in the assessment and management of mentally disordered offenders.

Part 1 comprises a literature review which was prompted by the observation that the term 'insight' was understood and used differently by mental health professionals working in forensic psychiatry as compared with general psychiatry. The review concludes that the meaning of the term 'insight' in forensic psychiatric practice is non-standardised, despite its role in risk assessment and risk management procedures. An ill-defined construct ('insight into offending behaviour') is identified. It is argued that this raises concerns about both ethical patient treatment and public safety. Further research is called for.

Part 2 describes a qualitative research project that investigated understanding and use of the term 'insight into offending' by psychiatrists and Home Office caseworkers involved in the risk assessment and risk management of mentally disordered offenders, and considers practices related to its assessment. The study concludes that there is considerable variety in understandings of the construct, beliefs about its importance in risk assessment procedures, and assessment practices relating to it. However, some general themes are identified.

Part 3 offers a critique of the research process described in Part 2, and discusses the study's strengths and limitations. It suggests directions for future research.

Table of contents

Acknowledgements.....	7
------------------------------	----------

Part 1: Literature Review: ‘The conceptualisation of patient insight in the literature relating to the risk assessment of mentally disordered offenders.’	9
--	----------

Abstract.....	10
Introduction.....	11
Method.....	18
Findings.....	18
Summary of findings.....	25
Discussion.....	26
References.....	34

Part 2: Empirical paper: Insight into offending behaviour’: how professionals define, use and assess the construct in the risk assessment of mentally disordered offenders.....	44
--	-----------

Abstract.....	45
Introduction.....	46
Method.....	51
Settings.....	52
Ethics.....	53
Participants.....	54
Procedure.....	56
Analysis.....	57

Validity checks.....	59
Position of researcher.....	60
Results.....	60
Theme 1: Caseworkers' and RMOs' views of the role of insight in risk assessment.....	61
1.1 Caseworkers' views	61
1.1.1. Relationship of insight to risk assessment..	61
1.1.2. Insight and rehabilitation.....	62
1.2 RMOs' views	64
1.2.1. Relationship of insight to risk assessment...	64
1.2.2. Insight and rehabilitation.....	65
1.3 Theme 1: Summary of views.....	68
Theme 2: Definitions of insight into offending behaviour...	69
2.1 Caseworkers' definitions.....	69
2.1.1. The cognitive-behavioural model.....	69
2.1.2 Moral reasoning: acceptance, understanding and remorse.....	70
2.1.3 Appreciation of personal consequences of the offence.....	71
2.2 RMOs' definitions	71
2.2.1 The cognitive-behavioural model.....	71
2.2.2 Moral reasoning: acceptance, understanding and remorse.....	72
2.2.3 Compliance with care team's understanding...	74
2.2.4 Insight is dynamic.....	74
2.3 Theme 2: Summary of views.....	74
Theme 3: Assessment of insight into offending.....	75

3.1 Caseworkers' beliefs about assessment.....	76
3.1.1 Behavioural assessment of insight.....	76
3.1.2 Insight can be assessed conversationally...	77
3.1.3 Insight can be assessed by verbal and behavioural consistency.....	77
3.1.4 Assessment is more difficult depending on diagnosis.....	78
3.2 RMOs' beliefs about assessing insight.....	79
3.2.1 Behavioural assessment of insight.....	79
3.2.2 Insight can be assessed conversationally.....	81
3.2.3 Insight can be assessed by verbal and behavioural consistency.....	81
3.2.4 Structured assessment of insight.....	82
3.3 Theme 3: summary of views.....	83
Discussion.....	83
References.....	91

Part 3: Critical Appraisal.....98

1. Development of the research question.....	99
2. Difficulties encountered during the research process.....	100
3. Methodological issues raised by the difficulties encountered.....	102
4. In defence of the study's validity and generalisability.....	103
5. How validity and generalisability could have been improved.....	106
6. The Interview schedule.....	108

7. Framework analysis.....	110
8. Limitations of this study and future research...	111
9. Conclusion.....	112
References.....	112

Appendices for Volume 1

Appendix 1: Ethical approval letter from Oxfordshire Ethics Committee A.....	115
Appendix 2: Ethical approval from Trust Lead for Research Site A) and Chair of Research and Development Committee (Site B).....	116
Appendix 3: Participant information sheet and consent Form.....	117
Appendix 4: Interview schedule.....	123
Appendix 5: Samples from interview transcripts.....	127
Appendix 6: Analysis: Frameworks.....	138
Appendix 7: Analysis: Samples from frameworks with data....	144
Appendix 8: Examples of charted data.....	150

Tables

Table 1: Demographics and professional history of Mental Health Unit Participants.....	55
Table 2: Demographics and professional history of RMO participants...	56
Table 3: Interview data: themes and sub-themes.....	60

Acknowledgements

Firstly, I wish to thank all those who took time out of busy work schedules to participate in this study and to provide such rich and thoughtful responses to my questions.

I wish to thank my supervisors for their help and support throughout the research process. The idea for this research was Dr Anne Sheeran's. She provided exceptional external supervision, helping me to develop the research and my thoughts about insight through many stimulating discussions and was always willing to discuss the project despite her many other commitments. Dr Chris Barker kindly responded to an early query regarding methodology with unofficial supervision that was sustained throughout the research process. His expertise and guidance regarding the methodology, analytic procedure and writing of the various sections were invaluable. Dr Mike Watts, my UCL supervisor, also provided great support, especially in the development of the interview schedule, provision of papers, and in the recruitment of RMOs.

Thanks also go to staff at the Home Office Mental Health Unit for their support, and in particular to David Parkin for taking the time to discuss the work of the unit with me and for recruiting caseworkers to the study. Penny Snow, Joint Head of Unit, also gave her time to meet with me and provide important background information for the study.

I am indebted to all those who enabled me to organise my domestic responsibilities in a manner that allowed me to complete this project with family life and mental health intact. Professor Val Curran, my academic tutor, initiated negotiations with college that enabled me to arrange my research schedule to fit in with the birth of my daughter. My parents encouraged and supported me throughout, both with academic advice and practical help. My sisters' contributions were also greatly appreciated: Isobel walked my son up and down outside the Home Office whilst I interviewed caseworkers and Helena provided emergency cover when childcare fell through. Helen, my children's nanny, provided first class stand-in mothering and enabled me to apply myself to this research without too much associated guilt. Finally, I wish to thank my husband Rich for his encouragement, his polite interest in 'insight into offending', and his belief that I could do this.

Part 1:

Literature Review

**‘The conceptualisation of patient insight in the literature
relating to the risk assessment of mentally disordered
offenders.’**

Abstract

Formal conceptualisation of the construct of 'insight' in general psychiatry has been a major research enterprise over the past twenty years. Debate about the construct continues, but it is generally accepted to refer to patients' understanding of their mental state. This review is prompted by the observation that the term 'insight' is also used by the forensic psychiatric community but with apparent differences in meaning. A review was undertaken to examine the use of the term in the current literature relating to the risk assessment and management of mentally disordered offenders. Seventeen papers were retrieved that referred to insight, but an important role for the construct in risk assessment was identified. It is argued that the small number of papers reflects the lack of research interest in this area. Within the identified literature, considerable variation in the use of the term 'insight' was noted. In many, but not all cases, 'insight' is used to refer to the patient's understanding of their offending behaviour, as well as, as part of, or instead of their mental illness. The models of this identified 'insight into offending behaviour' construct also varied. The paper concludes that there are serious ethical and public safety issues in the current non-standardised use of the insight construct within forensic psychiatric practice and calls for further empirical inquiry to formalise matters relating to its nature, value and clinical assessment.

The prediction of dangerousness in mentally disordered offenders is an issue of primary interest to forensic experts, policy-makers and the public. Offences against the person perpetrated by people with mental illnesses receive intense media coverage and reinforce public beliefs about the unpredictability and dangerousness of mentally ill people (Morrall, 2000; Taylor & Gunn, 1999). When a mentally disordered person commits an act of violence, government and public concern understandably focuses on the issue of public safety, and in particular on the chances of re-offence and the means by which those chances will be minimised (O'Rourke, Hammond & Davies, 1997). However, these offenders present special challenges to law enforcement, mental health and social care services, and the community at large.

The literature relating to the prediction and management of risk of violence in mentally disordered offenders continues to reflect the heterogeneity of scholarly opinion in this field (see Blumenthal & Lavender, 2001; Crighton, 2004, for summary). In the UK, the previous twenty years has seen the conclusions of a number of relevant public inquiries (see the NHS Report into the Care and Treatment of John Barrett, 2006, and earlier inquiries summarised by Parker & McCulloch, 1999), as well as the introduction of various policy initiatives aimed at improving the management of mentally disordered offenders (e.g., Home Office, 1992; the National Confidential Inquiry into Suicide and Homicide by Mentally Ill People described in Appleby, Shaw, Amos & McDonnell, 1999; government recommendations for those working with this patient group (e.g., Home Office, 1995); and the revision of the Mental Health Act of 1983 currently under way). Despite academic research, government investigations and policy initiatives, the whole issue of how these offenders are assessed and managed remains contentious. Forensic mental health

professionals are, however, expected to accurately assess risk of violence in their patients and to use their findings in the formulation of risk management plans.

Research findings over the past 40 years suggest a number of factors, both static (e.g., early experiences, offending history, diagnosis of personality disorder) and dynamic (e.g., negative attitudes, symptoms of major mental illness, insight), that appear to relate to the perpetration of violent acts by mentally disordered patients (Andrews & Bonta, 2003; Blumenthal & Lavender 2001; Webster, Douglas, Eaves & Hart, 1997). This knowledge has led to debate about the relative importance of these variables and the comparative virtues of actuarial models, which typically focus on static factors, versus clinical assessments of risk (e.g., Gardner, Lidz, Mulvey & Shaw, 1996; Gray et al., 2003; Dolan & Doyle, 2006). There is good evidence that actuarial measures are more accurate than pure clinical judgement and this has led to the argument that risk assessment should be based on explicit statistical models. (Monahan, 1981; Monahan & Steadman, 1994; Quinsey, Harris, Rice & Cormier, 2006). However, dynamic factors apparently contributing towards violent behaviour are not easily incorporated into such models. They necessarily require consideration of the individual variations in presentation that clinical assessment can accommodate, and as such their evaluation is best based on the good judgement of the expert (Hart, 1998). This exposes clinicians who include such factors in risk assessments to the criticism that their predictions are without empirical foundation (Hanson, 2002).

The past decade has seen an increasing recognition of the value of clinical judgements about dynamic risk factors that are made within a structured context informed by actuarially-derived information. This follows the continuing development of an

evidence-base confirming the usefulness such variables in the risk assessment process (e.g., Douglas, Ogloff & Hart, 2003; Doyle & Dolan, 2006; Elbogen, Van Dorn, Swanson, Swartz & Monahan, 2006). Consequently, there has been a shift towards the integration of actuarial and clinical approaches to violence risk assessment and an increasing interest in violence risk management. (Crighton, 2004; Dolan & Doyle, 2001). Empirically-based structured decision-making schemes have been developed which provide a systematic means of addressing the process of assessing, predicting and managing violence risk in mentally disordered offenders. The MacArthur Risk Assessment Study (Steadman et al., 1994) and the HCR-20 (Webster, Eaves, Douglas & Wintrup, 1995; Webster et al., 1997) are examples of such tools. These risk assessment tools include dynamic variables, but in doing so necessitate an evidence-based consensus among academics and clinicians regarding the definition and assessment of these clinically-evaluated factors if they are to avoid the accusation of non-standardisation.

The HCR-20 is one of the most widely-used structured risk assessment tools in the UK (Macpherson & Kevan, 2004). It lists patients' 'Lack of Insight' amongst its clinical (current) factors (variable C1). Its authors define this variable as a 'multi-dimensional construct' referring to the 'reasonable understanding and evaluation' of mental processes and the 'social consequences' of those, including violence risk. (Webster et al, 1997, p.50). The inclusion of insight in that scheme is echoed in the Risk for Sexual Violence Protocol (Hart et al., 2003), a tool also used in risk assessments of mentally disordered offenders, where 'Risk factor #8: Problems with self-awareness' is also described as 'lack of insight'. The variable in this tool refers to insight into both mental illness and the thoughts and behaviours leading to the offence

(p.56). Inclusion of lack of awareness or insight in this instrument is justified by the authors on the basis of its perceived critical position in theories and treatments of sexual violence (e.g., Finklehor, 1984; Hanson & Harris, 2000). 'Insight' appears again in the Behavioural Status Index (Woods, Reed & Robinson, 1999), a risk assessment and treatment planning instrument designed use within forensic psychiatry settings. In the UK, professional guidelines from various sources also specify its inclusion in the risk assessment process. The British Psychological Society's Faculty of Forensic Clinical Psychology lists the inclusion of questions relating to the patient's 'attitudes', 'awareness' and 'insight' into their risk behaviours and offences (BPS, 2006, p. 28). Similarly, the Home Office's Mental Health Unit requires that 'Responsible Medical Officers' who manage the treatment of mentally disordered offenders on 'restriction orders' under the Mental Health Act (1983) also consider patient 'attitudes' and 'insight', both in relation to mental illness and to the offence (Dent, 1997; Srinivas, Denvir & Humphreys, 2006). A Home Office commissioned review of the risk assessment literature for all offenders (including mentally disordered offenders) also lists 'lack of insight/remorse' in relation to offending behaviour as an important secondary risk variable in the prediction of recidivism (Powis, 2002, p.vii).

Evaluation of insight into mental state forms a standard part of patient assessment in general psychiatry (see, for example, practice guidelines published by the American Psychiatric Association, 2006, p.23). Insight - its definition, assessment, and management – has been a subject of interest and discussion in psychiatry since the middle of the nineteenth century and an important research focus since the 1980s (Markova, 2005). However, conceptualisation of this phenomenon of 'internal sight',

mental vision or perception (Oxford English Dictionary, 2002) has proved complex and empirical investigation difficult. This difficulty is reflected by the range of definitions that exists. For example, much of the work on insight in patients with organic brain syndromes uses a fairly narrow concept of insight as an awareness of specific deficits (Markova & Berrios, 2000). In general psychiatry, however, insight has been understood in a more general sense of awareness of illness (e.g. Amador & David, 2004; Young, Davila & Scher, 1993) and/or with further components incorporated into the concept – for example, attributions (Amador, Strauss, Yale & Gorman, 1991) and self knowledge (Gillett, 1994). Psychological perspectives also add further dimensions to conceptualisation of insight. Gestalt cognitive psychology views insight in terms of specific problem solving (Sternberg & Davidson, 1995), for example, whilst psychoanalytic writing refers to a different notion of insight as a deeper kind of internal ‘comprehension’ (Richfield, 1954). Empirical investigation and scholarly debate continues to work towards determining the individual components of insight and defining the boundaries of the construct. However, since the end of the nineteenth century, awareness of mental phenomena and mental change together with some judgement made by the patient concerning the illness affecting them has formed the core of the theoretical concept in general psychiatry (Markova, 2005).

Much of the research described above is relevant to the assessment and management of mentally disordered offenders as a sub-group of the general psychiatric population. The specific nature of insight in this population and its role in forensic risk assessment has not, however, been the focus of much empirical research despite its inclusion in the structured clinical assessment schemes, professional guidelines, and implied role

in theories of violence (Hart et al., 2003). This is possibly due to the ongoing investigation into insight in the context of mental illness and the accompanying debate, and perhaps an assumption that insight in forensic psychiatry is not substantially different to insight in a general psychiatry context.

Conceptualisations of insight in relation to mentally disordered offenders in the risk assessment literature cited above do, however, appear to differ from those that are applicable to general psychiatric patients. They apparently refer to the patient having insight into two issues: the mental illness and the offending or 'risk' behaviour, as well as into the relationship between them. Although there are some broader definitions in the insight into mental illness literature that might accommodate some of the implied additional components evident in the cited literature and guidelines (e.g., the multidimensional constructs described by Amador et al., 1993, and Beck, Baruch, Balter, Steer & Warman, 2004), these do not specifically refer to the detailed understanding of a particular behaviour (i.e. the offence) that the forensic literature implies. There is also a qualitative difference between assessment of insight in general psychiatry and in forensic psychiatry in that evaluation of the construct serves a risk assessment purpose, the outcome of which has broader social implications. Implicit in the inclusion of evaluation of insight in the risk assessment process (as outlined in the cited literature) is the notion that insight and the chances of recidivism are inversely related so that its presence or absence is expected to be predictive of behaviour. In general psychiatry, however, its assessment contributes to mental state examination and decisions about issues such as severity of illness and prognosis (Markova, 2005), so that clinicians' primary concern is not necessarily to use such findings to anticipate

future behaviour. Nor do these assessments necessarily have public safety implications.

Patient insight therefore appears to present a complex issue for clinical risk assessment and management of mentally disordered offenders. This paper is prompted by the apparent absence of direct investigation into this construct in the context of forensic psychiatry and the impression, gained from cursory consideration of the information described above, that there is no consensus as to the nature of insight in the mentally disordered populations. It describes the findings of a review of existing literature relating to the risk assessment of mentally disordered offenders and considers the use and value of the term 'insight' within that literature. It aims to summarise the existing relevant literature and to draw together its findings to answer the following research questions:

- (1) How is patient insight conceptualised in the literature relating to mentally disordered offenders: what is its nature, value to the risk assessment process and how should it be assessed?
- (2) Is there a consensus among researchers and clinicians working with this group regarding this construct?

It also aims to identify gaps in the existing research and future directions for empirical investigation.

Method

A literature review was carried out to identify existing research and commentaries published in peer-reviewed journals that referred to patient insight in mentally disordered offenders. Keywords were identified (insight, offending behaviour, mentally disordered offenders, recidivism). The relevant databases (PsychInfo, Pubmed, Crim Abstracts) were searched to find the studies that matched the search terms. Retrieved articles prompted searches with new key words identified as being used synonymously with insight or related to insight, or to describe a component of it (e.g., attitudes, cognitive distortions, attributions, empathy, remorse). All retrieved publications were then scrutinised and references were checked for relevance. Papers identified by the search engines as 'related articles' were also examined. Risk assessment tools currently in use within forensic settings in the UK were also hand-searched for examples of the use of the term 'insight' in relation to patients. Studies were included in the review that were judged to have direct relevance to answering the research questions. Thus papers that addressed the broader issue of risk assessment of offenders were included if they were considered to contribute to understanding of how patient insight is conceptualised and valued amongst clinicians and researchers working with mentally disordered offenders. The inclusion of this wider offender literature was justified by the findings of studies that have shown its relevance to the mentally disordered offender population (Bonta, Law & Hanson, 1998).

Findings

The literature search identified seventeen papers that referred directly to patient insight in mentally disordered offenders. These papers specifically described the assessment of insight as part of the risk assessment process, as part of assessment of other aspects of mentally disordered offenders' mental state or behaviour or the promotion of insight as part of treatment plans. Their explicit or implied definitions varied, however.

Papers were retrieved that described risk assessment or treatment planning schemes (including 'insight' assessment as part of that process) that have been described previously but are considered here in more detail. These were those relating to the HCR-20 (Douglas et al, 2001 Webster et al, 1994, 1995, & 1997), the Risk for Sexual Violence Protocol - RSVP (Hart et al, 2003) and the Behavioural Status Index (Woods, Reed & Robinson, 1999 & 2003). In including insight for measurement within their schemes, these authors necessarily provided more detailed descriptions of their understandings of the construct.

The HCR-20's 'multi-dimensional' model of insight is the best-elaborated definition in the available literature. It summarises the construct and its constituent factors as follows:

- (1) The patient's belief that they have a mental disorder
- (2) Their awareness of the implications and liabilities of their mental disorder
- (3) Their understanding of what might be done to address the disorder (Douglas et al, 2001, p.73).

This definition seems weighted towards insight into mental illness, but sees awareness of risky behaviours resulting from the mental disorder as part of that insight. Its authors specify that insight is demonstrated by 'self-perception' of dangerousness and understanding of personal risks for committing violent acts and understanding of the triggers that lead to such acts (p.73). There is also an implied dimension of social and moral reasoning present in the HCR-20's definition of insight. Its authors suggest insight involves not just the individual's ability to understand their own thought processes and actions, but also their capacity to understand how they relate to others and explain interpersonal events – for example, are they able to take responsibility? In addition, the authors consider 'insight' to be a dynamic construct, 'existing along a continuum, the range of which varies from person to person' (p.75). They also consider it to be a personal 'capacity': a variable trait that is affected by other factors of personality (p.76). A final dimension of insight is presented in the Companion Guide's (Douglas et al., 2001) suggested model for enhancing insight as part of patients' risk management programmes. This advises the use of motivational interviewing (Miller & Rollnick, 1991) to promote the expression of empathy, thus implying that that construct is closely related to (or forms part of) insight.

The RSVP (Hart et al., 2003) prefers the term 'Problems with self-awareness' to describe the construct it also defines as 'lack of insight'. This tool was designed for risk assessment of sex offenders generally, although it is used to assess mentally disordered offenders, and indeed includes 'mental disorder' as one of its five domains of risk factors. It seems likely that it is because of this target population that its definition of the awareness/insight construct stresses offenders' understanding of their offending behaviour more than their mental state, although it does refer to knowledge

of mental illness as part of self-awareness. Primarily, however, it focuses on 'impaired meta-cognition and failure to understand one's own crime cycle or offence chain' as evidence of lack of awareness/insight (p.56), as describes good insight as the ability to accurately self-appraise strengths, limitations, thought processes and associations between thoughts and behaviours. Unlike the HCR-20's definition, 'insight' as defined by the RSVP is does not imply inclusion of the broader social and moral aspects implied in that scheme.

The Behavioural Status Index (Woods et al., 1999, 2003) is a behaviourally-based risk assessment and treatment planning instrument designed for use in high-security forensic settings. It has three subscales: 'risk', 'insight' and 'communication and social skills'. Insight in this tool is also defined in terms of insight into behaviour and the causes of behaviours. The subscale's items target information about the patient's understanding of their own tension and anger levels, strategies for managing these, features of personal relationships that feed into offending/risky behaviours, understanding of the antecedent events leading to incarceration, ascription of responsibility and problem-solving skills. The scale does not measure insight into mental illness specifically – although insight into mental state may be necessary as part of patients' understanding of events leading to offending/risky behaviours. As is evident from the item content listed above, the Behavioural Status Index, like the HCR-20 and unlike the RSVP, does include the social and moral self-perception implied in the ability to see oneself in relation to others, and to take appropriate responsibility for behaviours.

In their inclusion of insight assessment their risk assessment schemes, the authors of the three risk assessment tools described above link presence of insight to reduced risk of re-offending. Interestingly Woods et al. (2003) examined the relationship between their conceptualisation of insight (described above) and risk of violence following the repeated administration of their instrument with a large sample of forensic patients (n=503) and subsequent factor analyses. Their hypothesis, that risk would be inversely related to insight as indicated by correlations between their two subscales, was not supported. They do not, however, interpret this finding as evidence of a weak relationship between insight and risk, referring to the work of Webster et al. (1994, 1995, 1997) as evidence of the importance of this construct in risk assessment. Instead they observe that their operationalisations of the risk and insight constructs may be responsible for their apparent independence, and that distortion of the relationship due to the strong intra-item association on the insight subscale was probably a further factor. They write of the 'logically-entailed notion' (p.515) that insight as they define it (insight into offending behaviour) is inversely related to risk of violence, that this is 'clinical logic', and that it is 'nonsensical to suggest that insight is not related to risk' (p.515).

Two papers that directly referred to insight in terms of offending behaviour were describing treatment approaches. Ferguson (1999) describes a risk assessment method ('eco-maps') that can also be used to facilitate learning-disabled forensic patients' rationalisation and understanding of the 'often complicated concepts which contribute to their behaviour' (p.1224). She calls this understanding 'insight'. Likewise, Huriwai (2002) describes a program aimed at substance addicted prisoners which promotes 'insight' (which it defines in terms of helping inmates to recognize and understanding

of thoughts, behaviours and emotions that precede criminal activity) alongside specific coping skills.

Three further papers used the 'insight into offending behaviour' construct in proposing models describing various phenomena relating to forensic psychiatric care or the management of prisoners. Timmerman, Vastenburg & Emmelkamp (2001) described the development of an assessment measure (the Forensic Inpatient Forensic Scale or FIOS), designed to facilitate evaluation of forensic inpatients' functioning that is independent of their risk of re-offending. It comprises six factors including 'insight into offence/problems'. 'Insight' as operationalised here is similar to the construct described by Woods et al. (1999, 2003) in that it is primarily concerned with the patients' insight into and attitudes towards their offending/risky behaviour and personal problems (e.g., relationships, addictions) that contribute towards these behaviours. Knecht, Morawitz & Schanda (1993) use a similar conceptualisation of 'insight' in their four-factor 'concept of further dangerousness', which describes the criteria against which decisions are currently made that relate to compulsory inpatient treatment of mentally disordered offenders in Austria. Lord & Willmott (2004) conceptualise insight in a similar way, though for the different purpose of describing the processes involved in sex offenders' denial of their offences. They list three 'group factors' that their findings indicate influence denial, including one they call 'motivational/insight'. Like Timmerman et al. (2001) and Knecht et al. (1993) these authors are concerned with the offender's insight into their offending behaviour and the factors that contribute towards it (which may or may not include variables related to mental illness). However, their work also suggests a social and moral realisation of wrong-doing in the offending behaviour (which involves the breakdown of cognitive

distortions that allow sex offenders to both offend and subsequently justify their actions) that motivates the offender to address their behaviour.

The understandings of 'insight' that primarily refer to patients' awareness of their behaviours (the risks, causes, consequences and severity of their actions) described above were not universal in the literature relating to mentally disordered offenders. Four papers (Arango, Bombin, Gonzalez-Salvador, Garcia-Cabeza & Bobes, 2006; Carroll, Pantelis & Harvey, 2004; Soyka, Graz, & Bottlender, 2007; Young, Spitz, Hillbrand & Daneri, 1999) described studies in which measures were taken of mentally disordered offenders' 'insight' that related to one of the accepted models of insight into mental illness (or at least one variable of those models). Young et al. (1999) reviewed the literature relating to forensic patients' willingness to comply with medication (which they sometimes referred to as 'insight') and the risk of recidivism. Considering the same question in their longitudinal study of previously violent schizophrenics, Arango et al. (2006) investigated the relationship between medication adherence and subsequent violence, and also used the term 'insight' to refer to treatment compliance. Soyka et al. (2007) considered the broader question of clinical correlates of offending behaviour in schizophrenics, and concluded that insight, as defined in terms of recognition of mental disorder and the need for treatment, was an important clinical factor predictive of subsequent offending. Finally, Carroll et al. (2004) used a similar operationalisation in exploring the relationship between insight (as confined to measures of the 'compliance' and 'awareness of illness' domains on David's (1990) Schedule for the Assessment of Insight) and hopelessness.

One paper offered an apparently unique conceptualisation of insight in the context of mentally disordered offenders. Buckley et al. (2004) considered insight and its relationship to violent behaviour in previously violent schizophrenics. These authors divided insight assessment into two areas: insight into illness, and insight into 'the legal consequences of illness' – a construct they term 'forensic insight'. It is interesting that insight into the offending behaviour – its nature, triggers and consequences – is not included in this definition.

Summary of findings

The majority of retrieved papers described conceptualisations of insight in relation to mentally disordered offenders that primarily focussed on insight into offending behaviour, and specifically on patients' understanding of circumstances leading to the offence/risky behaviour. Insight into mental illness was apparently considered to be related to insight into offending behaviour by the authors of these papers. For the most part, it was implied that insight into mental illness was a component of insight into offending behaviour, in that it might constitute one of the contributing factors leading to the offence (e.g., Ferguson, 1999; Hart et al., 2003; Timmerman et al., 2001). On the other hand, Webster et al.'s definition (1994,1995,1997) as operationalised in the HCR-20 suggests the opposite relationship: that insight into behaviour is part of insight into mental illness. Some authors, however, used the term 'insight' in the context of this group without making reference to insight into behaviour at all: their definitions, for the purposes of the studies in questions, were solely concerned with the patients' insight into their illnesses and apparent expressions of this (e.g., Carroll et al., 2004; Young et al., 1999). These

understandings reflect accepted understandings of insight in general psychiatry – understandings including the acknowledgement of mental illness and the need for treatment as demonstrated by adherence to treatment plans (e.g., APA Practice Guidelines, 2006).

Some of the better-elaborated definitions of the construct suggest that a component of insight within this population is the social self-perception necessary for understanding how one relates to others and for accurate appraisal of interpersonal events (Douglas et al., 2001; Wood et al., 2003). One of these publications implied that empathy is a part of this social self-awareness (Douglas et al., 2001). Both these models and one other (Lord & Willmot, 2004) suggest that good insight demands the moral awareness necessary for the ability to take responsibility (Douglas et al., 2001; Wood et al., 2003), and to acknowledge the wrong-doing that is the offending behaviour (Lord & Willmot, 2004). These aspects were not explicitly suggested elsewhere.

One paper offered a definition of insight in relation to this patient population that did not appear elsewhere: the concept of ‘forensic insight’, which its authors defined as a patient’s understanding of the legal consequences of their illness (Buckley et al., 2004).

Discussion

The literature review described above provides good evidence of variation in definition and use of the term ‘insight’ in the literature relating to mentally disordered offenders, thus confirming the researcher’s impression of non-standardisation that

prompted this investigation. These findings provide a negative answer to the second research question, which asked whether a consensus exists in the literature regarding this construct. By way of addressing the first research question, which asked about how 'insight' is conceptualised by writers concerned with the assessment and management of mentally disordered offenders, this section describes trends and differences in conceptualisations of insight, and explicit and implicit beliefs about its components, value and assessment.

As previously described, the search retrieved just seventeen papers relevant to the assessment and management of mentally disordered offenders that directly referred to insight. It is important to note that there may be search process reasons contributing to this small result. The databases used operate by searching for keywords in the titles and abstracts of papers and it therefore seems likely that other relevant papers exist that use the term insight (although these are likely to have other focuses than insight itself). However, it might also be argued that the fact that this relatively small number of relevant papers were identified gives credence to the present study and its call for further research into insight this context. It is clear from the fact that only one of the papers had a primary purpose of examining the construct of insight and its role in recidivism (Woods, Reed & Collins, 2003) that the main reason for the dearth of literature in this area is the apparent lack of research interest. It seems that there has been little acknowledgement of the non-standardised use of the construct in the offending context and little (if any) attempt to investigate or address this. In addition, examples of the term's usage just within those papers that were retrieved are sufficient to support the argument presented in the introduction of this paper that

insight is conceptualised differently by professionals working with mentally disordered offenders to those working in general psychiatry.

The literature described here provides some idea of how insight is currently conceptualised in forensic psychiatry. As discussed in the introduction to this paper, it is clear that many researchers and clinicians in this field do consider insight in forensic patients to include, or refer exclusively, to insight into the offending behaviour. This 'insight into offending behaviour' construct is not, however, defined consistently in the literature.

In many cases, authors suggest that this type of insight is demonstrated, at least in part, by the detailed understanding of the cognitive, behavioural, circumstantial and interpersonal antecedents of the offending/risky behaviour and the consequences of that behaviour (e.g., Ferguson, 1999; Hart et al., 2003; Huriwai, 2002; Timmerman et al., 2001; Woods et al., 1999, 2003). These conceptualisations are perhaps not surprising, as they reflect the fact that it is the promotion of this kind of self-awareness that is often the focus of cognitive-behavioural risk management programmes in forensic psychiatry settings (e.g., Douglas, Webster, Hart, Eaves & Ogloff, 2001), and prisons, as Hart et al. (2003) point out. However, this definition of the 'insight into offending behaviour' construct, although widespread in this literature, was not exclusive. Other writers included the moral and social elements to self-understanding described in the previous section (e.g., Douglas et al., 2001; Lord & Willmott, 2004; Woods et al., 1999, 2003). Primarily, these aspects of self-awareness seem to involve recognition of wrong-doing and acceptance of personal culpability for the offending behaviour. It can be assumed, therefore, that these clinicians, when

assessing, would require demonstration of this insight through an appropriate expression of this realisation. Researchers who refer to these issues in their papers do not, however, elaborate on what such a demonstration would look like. It seems plausible to speculate that these writers might expect expression of remorse or guilt, or perhaps evidence of this in apparent psychological distress. A related concept is the expression of empathy for the victim of offences, that Douglas et al. (2001) suggest should be sought in psychological work promoting insight in mentally disordered offenders.

These aspects of insight suggest an emotive dimension to the conceptualisation of insight into offending behaviour that differs from the more cognitive insight targeted by the offending behaviour treatment programmes discussed above (and reflects the concepts of 'intellectual' and 'emotional' insight, described in Beck et al., 2004, that are one of the recent additions to the literature focussing on insight into mental illness). Interestingly, however, the concept of 'forensic insight' proposed by Buckley et al. (2004) differs from the other conceptualisations of offence-related insight. This concept appears to describe a non-emotive insight that is different to the detailed cognitive-behavioural understanding of the offence described above. In focussing on the 'legal consequences' of the offence, it suggests that it is less concerned with the moral and social implications of offending behaviour, and more with the consequences of detection and conviction (i.e., incarceration and the impact of that on the patient's own life).

It is, perhaps, not surprising that understandings of the insight construct in work relating to mentally disordered offenders should differ so fundamentally. The dual

status of the mentally disordered offender as offender and psychiatric patient means that clinical work includes another important factor besides treatment of the mental disorder: the management of future risk of offending. In the case of most forensic patients, this 'risk management' involves promotion of the patients' awareness of (or 'insight' into) the personal and circumstantial factors that led to the index offence and the ways in which future offending can be avoided (Needs & Towl, 2004). This treatment focus would explain the general trend in forensic psychiatry to include these offending behaviour-related dimensions in conceptualisations of insight that are not considered in general psychiatry. What is surprising, however, is the apparent lack of interest in the formal operationalisation of this 'insight into offending' construct. Despite the apparent existence of some informally agreed themes among some researchers and clinicians in this area (e.g., the cognitive-behavioural understanding of antecedents, behaviours and consequences, and the moral and social implications of offences), there are differences in conceptualisations of insight that might be accounted for by this oversight in the research literature. As seems evident even from the small number of papers examined, in the forensic psychiatric field the term 'insight' can be understood to refer to a number of concepts. It is important to note that the term is also used in the offending behaviour literature to refer to understandings that are accepted in general psychiatry and make no reference to offending behaviour (e.g., Carroll et al., 2004; Young et al., 1999). This adds further to the confusion.

This review has revealed variation in definition of insight within the literature where the term is used, and an absence of papers either proposing models of the construct or investigating its use, value and assessment within the management of mentally

disordered offenders. The risk assessment schedules that include measures of insight propose areas of questioning that fit with their own conceptualisations of the construct for the purposes of assessment. However, in the absence of consensus regarding definition and consequently standardisation of its assessment across the forensic psychiatric community, it is concerning that evaluation of this construct is considered instrumental in decisions relating to the restraint and liberty of both mentally disordered offenders and prisoners (Powis, 2002). The value of assessment of insight to the risk assessment procedure is clearly widely accepted in the field (e.g., Woods et al., 2003), due primarily to the empirical basis of the HCR-20 (Webster et al., 1994, 1995, 1997). The empirical strength of that assessment scheme may provide foundation for Woods et al.'s (2003) assertion that it is 'clinical logic' that insight assessment is an important component to any risk assessment, and that it is 'nonsensical' to suggest that insight is not related to risk (p.515). However, considering the lack of a standard operationalisation of the construct in the literature, as well as empirical investigation into its use and value, there are clearly grounds for questioning its current position in risk assessment processes. Research is needed to help clarify the nature of the construct and to empirically examine the various conceptualisations of insight in this field and their relationship to other clinical variables.

Differences between authors' understandings of insight identified in this review suggest some areas for future investigation. Primarily, it is important that the nature and value of the 'insight into offending behaviour' construct that emerges repeatedly in the existing literature (and in the professional and government guidelines described in the introduction to this paper) are formalised, and that assessment practices related to it standardised. The cited literature indicates that the

inclusion in risk assessment of a measure of insight concerned with offenders' understanding of their offending behaviour is widely believed to have face validity. However, this paper has shown that there remain apparent differences in researchers' and clinicians' beliefs regarding the nature of this construct. The authors cited in this paper's findings include or exclude in their definitions (implicitly or explicitly) a number of factors. These include a detailed understanding of the antecedents, behaviours and consequences relating to the offence (e.g., Ferguson, 1999; Huriwai, 2002; Woods et al., 1999; 2003); insight into mental illness and the role that illness plays in the offence (e.g., Hart et al., 2003); acceptance of responsibility (e.g., Woods et al., 1999; 2003); expression of remorse/regret (e.g., Douglas et al., 2001); evidence of guilt and/or psychological distress (Lord & Willmott, 2004); expression of victim empathy (e.g., Douglas et al., 2001); absence of denial (or minimisation) of the offence (Lord & Willmott, 2004); and acknowledgement of the 'legal' consequences of the offending behaviour (Buckley et al., 2004). The role, if any, of each of these proposed components in a clinically useful 'insight into offending' construct remains to be established. Examination of the assumptions implicit in the described conceptualisations is particularly important in light of recent research findings that question the relationship of some of these dynamic variables to the risk of violent recidivism (e.g., Hanson & Morton-Bourgon, 2005; Jolliffe & Farrington, 2004). A further, and related, area for future inquiry is research leading to clarification of the relationship between insight into mental illness and this 'insight into offending behaviour' concept. As described previously, authors vary in terms of the emphasis they place on insight into mental illness in their conceptualisation of insight within this patient group for whom there is the additional status of offender. As noted previously, some use the term 'insight' in the context of mentally disordered

offenders with no reference to behavioural understanding and a sole focus on illness (e.g., Carroll et al., 2004; Young et al., 1999). For others, insight into illness and insight into offending constitute parts of the construct, although authors appear to vary in terms of which of these two elements they consider primary (e.g., Douglas et al., 2001; Hart et al., 2003). The literature does not present a standard view on this matter and the relationship between these two variables remains unclear: are they part of each other? If so, which variable is dominant? Indeed, are they part of the same construct or independent of each other? These questions remain to be answered and are potentially fruitful areas for future research.

The review was prompted by a perception that insight as a dynamic variable in psychiatric assessment is conceptualised differently in the forensic psychiatric community as compared with its accepted use within the general psychiatric literature. This impression has been borne out in the findings described here. The ethical implications of the inclusion of non-standardised variables, such as ‘insight into offending’, in risk assessments of mentally disordered are too significant to ignore. Both the welfare and human rights of patients and the safety of the general public are affected by such imprecision. Areas for future research have been suggested. In particular, this paper calls for clarification of the nature and clinical value of the ‘insight into offending behaviour’ construct identified here and examination of the practises relating to its assessment.

References

Amador, X.F. & David, A. (2004). *Insight and Psychosis. Awareness of Illness in Schizophrenia and Related Disorders, 2nd Edition*. Oxford: Oxford University Press.

Amador, X.F., Strauss, D.H., Yale, S.A., & Gorman, J.M. (1991). Awareness of illness in schizophrenia. *Schizophrenia Bulletin*, 17, 113-132.

American Psychiatric Association (2006). *Practise Guidelines for the Psychiatric Evaluation of Adults (2nd Edition)*. Arlington, VA: American Psychiatric Publishing Inc.

Andrews, D., & Bonta, J. (2003). *The Psychology of Criminal Conduct (3rd ed.)*. Cincinnati, Ohio: Anderson Publishing Company.

Appleby, L., Shaw, J., Amos, T. & McDonnell (1999). *Safer Services: National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*. London: HMSO.

Arango, C., Bombin, I., Gonzalez-Salvador, T., Garcia-Cabeza I. & Bobes J. (2006). Randomized clinical trial comparing oral versus depot formulations of zuclopenthixol in patients with schizophrenia and previous violence. *European Psychiatry*, 21 (1), 34-40.

Beck , A.T., Baruch, E., Balter, J.M., Steer, R.A. & Warman, D.M. (2004). A new instrument for measuring insight: the Beck Cognitive Insight Scale. *Schizophrenia Research*, 68, 319-329.

Blumenthal, S. & Lavender, T. (2001). *Violence and Mental Disorder: A Critical Aid to the Assessment and Management of Risk*. London: Jessica Kingsley Publishers.

Bonta, J., Law, M. & Hanson, K. (1998). The Prediction of Criminal and Violent Recidivism among Mentally Disordered Offenders: A Meta-Analysis. *Psychological Bulletin*, 122, 123-42.

Buckley, P.F., Hrouda, D.R., Friedman, L., Noffsinger, S.G., Resnick, P.J. & Camlin-Shingler, K. (2004). Insight and its relationship to violent behaviour in patients with schizophrenia. *American Journal of Psychiatry*, 161 (9), 1712-4.

British Psychological Society (2006). *Occasional Briefing Paper No. 4: Risk Assessment and Management*. Leicester: The British Psychological Association.

Carroll, A., Pantelis, C. & Harvey, C. (2004). Insight and hopelessness in forensic patients with schizophrenia. *Australian and New Zealand Journal of Psychiatry*, 3, 169-173.

Crighton, D. (2004). Risk Assessment. In A. Needs & G. Towl (Eds.), *Applying Psychology to Forensic Practice* (pp.64-81). Oxford: Blackwell.

David, A.S. (1990). Insight and psychosis. *British Journal of Psychiatry*, 156, 798-808.

Dent, S. (1997). The Home Office Mental Health Unit and its approach to the assessment and management of risk. *International Review of Psychiatry*, 9, 265-271.

Dolan, M. & Doyle, M. (2001). Violence risk prediction. Clinical and actuarial measures and the role of the Psychopathy Checklist. *British Journal of Psychiatry*, 178 (1), 84-85.

Douglas, K.S., Ogloff J.R. & Hart, S.D. (2003). Evaluation of a model of violence risk assessment among forensic psychiatric patients. *Psychiatric Services*, 54 (10), 1372-9.

Douglas, K.S., Webster, C.D., Hart, S.D., Eaves, D. & Ogloff, J.R.P. (2001). *HCR-20 Violence Risk Management Companion Guide*. Burnaby, British Columbia: The Mental Health Law and Policy Institute, Simon Fraser University.

Doyle, M. & Dolan, M. (2006). Predicting community violence from patients discharged from mental health services. *British Journal of Psychiatry*, 189, 520-526.

Eastman, N. (2006). Can there be true partnership between clinicians and the Home Office? *Advances in Psychiatric Treatment*, 12, 459-461.

Elbogen, E.B., Van Dorn, R.A., Swanson, J.W., Swartz, M.S. & Monahan, J. (2006).

Treatment engagement and violence risk in mental disorders. *British Journal of Psychiatry*, 189, 354-60.

Ferguson, D. (1999). Eco-maps: facilitating insight in learning-disabled sex offenders.

British Journal of Nursing, 8 (18), 1224-1231.

Finklehor, D. (1986). *A Sourcebook on Child Sexual Abuse*. London: Sage.

Gardner, W., Lidz, C.W., Mulvey, E.P. & Shaw, E.C. (1996). Clinical versus actuarial predictions of violence of patients with mental illnesses. *Journal of Consulting and Clinical Psychology*, 64 (3), 602-609.

Gillet, G. (1994). Insight, delusion and belief. *Philosophy, Psychiatry and Psychology*, 1, 227-236.

Gray, N.S., Hill, C., McGleish, A., Timmons, D., MacCulloch, M.J. & Snowden, R.J (2003). Prediction of violence and self-harm in mentally disordered offenders: a prospective study of the efficacy of HCR-20, PCL-R, and psychiatric symptomatology. *Journal of Consulting and Clinical Psychology*, 71 (3), 443-51.

Hanson, R.K. & Harris, A.J.R. (2000). Where should we intervene? Dynamic predictors of sexual offence recidivism. *Criminal Justice and Behaviour*, 27, 6-35.

Hanson, R.K. (2002). Introduction to the special section on dynamic risk assessment with sex offenders. *Sexual Abuse*, 14, 99-101.

Hanson, R. K. & Morton-Bourgon K.E., (2005). The characteristics of persistent sexual offenders: a meta-analysis of recidivism studies. *Journal of Consulting and Clinical Psychology*, 73 (6), 1154-63.

Hart, S. D. (1998). The Role of Psychopathy in Assessing Risk for Violence: Conceptual and Methodological Issues. *Legal and Criminological Psychology*, 3, 121-37.

Hart, S. D., Kropp, P.R., Laws, D.R., Klaver, J., Logan, C., & Watt, K.A. (2003). *The Risk for Sexual Violence Protocol (RSVP): Structured Professional Guidelines for Assessing Risk of Sexual Violence*. Burnaby, British Colombia: Simon Fraser University, Pacific Psychological Assessment Corporation & The British Colombia Institute Against Family Violence.

Home Office (1992). *The Reed Committee Report of the Review of Services for Mentally Disordered Offenders*. London: HMSO.

Home Office and the Department of Health (1995). *Mentally Disordered Offenders: Inter-agency working*. London: HMSO.

Huriwai, T. (2002). Innovative alcohol and drug user treatment of inmates in New Zealand prisons. *Substance Use and Misuse*, 8-10, 1035-1045.

Jolliffe, D. & Farrington, D.P. (2004). Empathy and offending: A systematic review and meta-analysis. *Aggression and Violent Behaviour*, 9, 441-476.

Knecht, G., Morawitz, I. & Schanda, H. (1993). Discharge of incompetent mentally abnormal criminals: experience from the Austrian central treatment institution.

International Journal of Law and Psychiatry, 20 (5), 181-5.

Lord, A. & Willmot, P. (2004). The process of overcoming denial in sexual offenders.

Journal of Sexual Aggression, 10 (1), 51-61.

Macpherson, G.J.D. & Kevan, I. (2004). Predictive validity of the HCR-20 Violence Risk Assessment Scheme within a maximum security special hospital. *Issues in Forensic Psychology*, 5, 62-80.

Markova, I.S. (2005). *Insight in Psychiatry*. Cambridge: Cambridge University Press.

Markova I. S. & Berrios, G.E. (2000). Insight into memory deficits. In *Memory Disorders in Psychiatric Practice*. Eds. G. E. Berrios & J.R. Hodges. Cambridge: Cambridge University Press.

Mental Health Act (1983). In Department of Health (1998), *Code of Practice to Mental Health Act 1983*. London: HMSO.

Miller, W.R. & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behaviour*. New York: Guildford.

Moody, E., & Snow, P. (2005). Mental Health Unit. *The British Journal of Forensic Practice*, 7 (4), 21-26.

Monahan, J. (1981). *The Clinical Prediction of Violent Behaviour*. Beverly Hills: Sage.

Monahan, J & Steadman, H.J. (1994). *Violence and Mental Disorder: Developments in risk assessment*. Chicago: University of Chicago Press.

Morrall, P. (2000). *Madness and Murder*. London: Whurr.

Needs, A. & Towl, G. (2004). *Applying Psychology to Forensic Practice*. Oxford: Blackwell.

NHS (2006). *Report into the Care and Treatment of John Barrett*. London: NHS.

O'Rourke, M.M., Hammond, S.M., & Davies, J. (1997). Risk assessment and risk management: the way forward. *Psychiatric Care*, 4, 132-138.

Parker, C. & McCulloch A. (1999). Key issues from homicide inquiries. *British Journal of Psychiatry*, 174, 9-14.

Powis, B. (2002). *Offenders Risk of Serious Harm: A literature review*. Home Office Research, Development and Statistics Directorate Occasional Paper 81. London: HMSO.

Quinsey, V.L., Harris, G.T., Rice, M.E. & Cormier, C.A. (2006). *Violent Offenders: Appraising and Managing Risk (2nd Edition)*. Washington DC: American Psychological Association.

Richfield, J. (1954). An analysis of the concept of insight. *Psychoanalytic Quarterly*, 23, 390-408.

Soyka, M., Graz, C. & Bottlender, R. (in press). Clinical correlates of later violence and criminal offences in schizophrenia. *Schizophrenia Research*.

Srinivas, J., Denvir, S. & Humphreys, M. (2006). The Home Office Mental Health Unit. *Advances in Psychiatric Treatment*, 12, 450-458.

Steadman, H.J., Monahan, J., Appelbaum, P., Grisso, T., Mulvey, E.P., Roth, L.H., Robbins, P. & Klassen, D (1994) Designing a new generation of risk assessment research. In J. Monahan & H.J. Steadman (Eds.) *Violence and Mental Disorder: Developments in risk assessment*. Chicago: University of Chicago Press.

Sternberg R.J. & Davidson J.E. (1995). *The Nature of Insight*. London: MIT Press

Taylor, P.J. & Gunn, J. (1999). Homicides by People with Mental Illness: Myth and Reality. *British Journal of Psychiatry* 174, 9-14.

Timmerman, I.G., Vastenburg N.C.& Emmelkamp P.M. (2001). The Forensic Inpatient Observation Scale (FIOS): development, reliability and validity. *Criminal Behaviour and Mental Health*, 11 (3), 144-162.

Webster, C., Douglas, K., Eaves, D. & Hart, S. (1997) *HCR-20: Assessing Risk for Violence (version 2)*. Burnaby, British Columbia: The Mental Health Law and Policy Institute, Simon Fraser University.

Webster, C., Eaves, D., Douglas, K., & Wintrup, A. (1995). *The HCR-20 Scheme: Assessing Risk for Violence*. Burnaby, British Columbia: Simon Fraser University and Forensic Psychiatric Services Commission of British Columbia.

Webster, C.D., Harris, G.T., Rice, M.E., Cormier, C. & Quinsey, V.L (1994). *The Violence Prediction Scheme*. Toronto: University of Toronto Press

Woods, P., Reed, V., & Collins, M. (2003). The relationship between risk and insight in a high-security forensic setting. *Journal of Psychiatric and Mental Health Nursing*, 10 (5), 518-525.

Woods, P., Reed, V., & Robinson, D. (1999). The Behavioural Status Index: therapeutic assessment of risk, insight, communication and social skills. *Journal of Psychiatric and Mental Health Nursing* 6 (2), 79-90.

Young, D.A., Davila R & Scher, H. (1993). Unawareness of illness and neuropsychological performance in chronic schizophrenia. *Schizophrenia Research*, 10, 117-124.

Young, J.L., Spitz, R.T., Hillbrand, M. & Daneri, G. (1999). Medication adherence failure in schizophrenia: a forensic review of rates, reasons, treatments, and prospects. *Journal of the American Academy of Psychiatry and Law*, 27 (3), 426-44.

Part 2:

Empirical paper

**‘Insight into offending behaviour’: how professionals define,
use and assess the construct in the risk assessment of
mentally disordered offenders.**

Abstract

The construct 'insight into offending behaviour' is discussed within forensic psychiatry and psychology and the UK Home Office in the context of risk assessment and decision-making about mentally disordered patients' treatment and rehabilitation. To date there appears to have been little research interest into the meaning, importance, or assessment of this construct. The present study used qualitative methodology to explore understandings of the construct and its assessment among two groups of professionals involved in decision-making about mentally disordered offenders. Eleven forensic psychiatrists and five Home Office caseworkers participated in semi-structured interviews. Data were analysed using framework analysis. The findings identified some agreement but also some diversity in conceptualisations and clinical practices. All participants demonstrated a personal understanding of the construct and considered it relevant to risk assessment, though they varied in their beliefs as to its relative importance in this process. A number of working models of insight into offending were elicited, and a variety of beliefs as to how it is best assessed. Directions for future research are suggested.

Mentally disordered offenders bear two characteristics that may relate to each other in various ways: their diagnosed psychiatric condition and their offending behaviour (Arboleda-Forez, Holley & Crisanti, 1998). They consequently occupy two identities – those of patient and convicted criminal. Assessment and management of these patients therefore poses a number of problems, both for psychiatric services and the criminal justice system. One such area of difficulty is rehabilitation. When mentally disordered offenders return to the community, the primary concern for clinicians, politicians, and the general public is accurate risk assessment, especially where the offending behaviour was violent. It is, however, widely agreed among clinicians that it is extremely difficult to assess the risk of violence that these patients pose (Bonta, Law & Hanson, 1998; Dolan & Doyle, 2001). It is also widely accepted that it is a skill essential to mental health professionals. Despite the enormous quantity of research focussed on this issue over the previous three decades (Blumenthal & Lavender, 2001; Crighton, 2004), it is still not possible to predict risk of violence accurately, and the issue of assessment remains contentious.

A number of factors appear to relate to the perpetration of violent acts (Andrews & Bonta, 2003; Blumenthal & Lavender 2001; Webster, Douglas, Eaves & Hart; 1997). This knowledge has led to the development of both actuarial instruments and structured clinical guidelines intended for use in risk assessment. Current thinking in forensic psychiatry is that assessment should involve both actuarial and clinical components (with the actuarial informing the clinical), and that past and current behaviour are useful indicators of potential future behaviour (Crighton, 2004; Dolan & Doyle, 2000). Both static (e.g., previous violence, personality problems) and dynamic risk factors (e.g., attitudes, cognitions) have been considered relevant to risk

assessment, though debate continues about the relative importance of these different types of factors (see Dolan & Doyle, 2006; Gardner, Lidz, Mulvey & Shaw, 1996; Gray et al., 2003). The patient's 'insight' into their behaviour is one dynamic factor that some theorists have argued should be included in risk assessments (Hart et al., 2003; Webster et al., 1997; Woods, Reed & Robinson, 1999). It has been argued that forensic patients' potential risk is related to their level of personal insight into the causal elements and circumstances surrounding their offence, their personal experiences, and their ability to exert control over the anxieties and related behaviours that led to the offence (Woods et al., 1999). Indeed it is this cognitive-behavioural conceptualisation of 'insight' that is the goal of many psychological treatment programmes in forensic settings (e.g., the influential Reasoning and Rehabilitation programme (Ross & Ross, 1995) and related programmes such as the Cognitive Self Change programme (Bush, 1995).

Insight into mental illness – its nature and presence or absence in mentally disordered patients - has been a major research focus in psychiatry for the past twenty years, although conceptualisation of the term has proved complex and its translation into forms amenable to empirical assessment difficult (see Markova, 2005). The term in the context of offending behaviour, however, has not been explicitly defined or discussed in the psychiatric literature despite the accepted use of the term within forensic psychiatry (e.g. Srinivas, 2006; Webster et al., 1997; Woods et al., 1999), the civil service (e.g., Dent, 1997; Powls, 2002), and the UK criminal justice system (e.g., Parole Board, 1997; Home Office documentation, 2004). The question as to how it is best assessed remains equally obscure. This is possibly due to the ongoing investigation into insight in the context of mental illness, and perhaps an assumption

that insight into offending behaviour constitutes some part of that. Indeed, some theorists' definitions might be interpreted in this way (e.g. the 'multidimensional' construct described by Amador, Strauss, Yale & Gorman (1991) – who include understanding of the social consequences of illness in their definition - or the wider conceptions in the psychoanalytic literature such as that implied by Weinstein & Kahn, 1955). However, the exact relationship between insight into mental illness and insight into offending behaviour is not clear. It is equally unclear how the insight into offending behaviour construct might relate to other terms used to describe cognitive-emotional processes about particular behaviours (e.g. 'attitudes', 'values', 'attributions', 'beliefs', 'self-knowledge'), and, of specific concern to the forensic psychological and psychiatric communities, to the chances of recidivism.

Despite the lack of discussion and therefore consensus as to the nature and relative importance of insight into offending behaviour, its non-standardised assessment by forensic psychiatrists and psychologists forms part of risk assessment and the decision-making process regarding the treatment of mentally disordered offenders. The reasoning behind this - the 'logically entailed notion' (Woods, Reed & Collins, 2003, p.515) that insight into offending behaviour is inversely related to the chances of recidivism - is not a hypothesis that has been empirically tested. It is, however, widespread amongst clinicians and within the UK criminal justice system, as described above, and influential in decisions that have significant implications both for patients (their treatment, welfare, and civil rights) and public safety.

In Britain the detention and treatment of mentally disordered offenders involves two bodies: forensic psychiatric services and the Home Office's Mental Health Unit. Part

III of the Mental Health Act (1983) provides for the admission to hospital by the courts of convicted offenders who are judged by two doctors to be mentally disordered, and to be likely to benefit from hospital treatment (section 37). If there is concern that the offender poses a risk of 'serious harm' to the public, the Crown Court can also add a restriction order (under section 41), which devolves all decisions regarding leave of absence, transfer and discharge from the hospital to the Home Secretary (except in the case of discharge, which the Mental Health Tribunal may also direct). In these cases a 'responsible medical officer' (RMO), usually a consultant psychiatrist, is named for each patient subject to it, and it is s/he who oversees the patient's treatment in hospital. Where restriction orders are applied, the Home Office requires the RMO to provide reports on the patients' progress annually and when requesting leave, transfer or discharge of that patient.

In November 2005, the Home Office held responsibility for some 4,600 restricted patients, 3,300 of whom were detained in hospital (Snow & Moody, 2005). It is the role of the Mental Health Unit (MHU) to advise the Home Secretary in the exercise of his power regarding the management of these patients. In practice, however, it can make decisions about most patients on his behalf. The Unit's stated aim is to protect the public from further offending by dangerous restricted patients, by supporting their effective management in hospital and assisting in their safe rehabilitation into the community (Snow & Moody, 2005). To this end, the unit's caseworkers review restricted patients' annual reports, as well as proposals for leave, transfer, or discharge, leading to approximately 15,000 decisions in the year 2004-5 (Snow & Moody, 2005). It is this casework that occupies most of the time of staff (Dent, 1997).

The MHU's *Guidance to Responsible Medical Officers* (October 2006) describes its work as assessing, through analysis of regular clinical reports, the perceived present and future dangerousness of patients. It also evaluates the measures taken by the clinical team to manage existing risk and identify signs of future relapse (Snow & Moody, 2005). As part of this assessment process RMOs are required to provide the Home Office with clinical judgements about the extent and nature of a patient's 'insight' into their behaviour and mental processes (cited in Dent, 1997 and *Guidance to Responsible Medical Officers*). It also asks specifically whether the patient's reported 'insight' is 'real or ... 'learned'' (Dent, 1997). The documentation also refers to other internal processes including the patient's 'motivation to change and to progress' (Dent 1997); and 'current attitudes' to the offending behaviour (*Guidance to Responsible Medical Officers*). Elsewhere, the Home Office requests descriptions of any 'objective evidence' for internal 'change beyond good behaviour' (Dent, 1997). These integral parts of the Home Office assessment therefore require the clinician to evaluate apparently related internal constructs which are variably described in the Home Office literature in terms such as 'insight', 'attitudes to offending', and 'change'. In essence, these constructs appear to refer to the patient's ability or inability to understand and evaluate their offending behaviour and mental processes, and to accept responsibility both for past actions and for taking precautions to avoid inflicting further harm in the future. However, it is not clear how these constructs are related, or whether they refer to the same, or elements of the same, internal processes.

The present study explores the ways in which these two groups (MHU caseworkers and RMOs) understand and use the terms relating to patient 'insight into offending', how they make assessments of it, and their experiences of decision-making with

regards to it. It will use the qualitative method of framework analysis with interview data from both Home Office caseworkers and RMOs. It aims to explore participants' assumptions about insight into offending and its relationship with recidivism, and to investigate uncertainty in this area of forensic assessment. It does this with the broader aim of opening up discussion in this area and paving the way for future research that moves the forensic community towards a shared conceptualisation of insight into offending and a better understanding of its true value in the context of clinical assessment. Specifically, it asks:

- (1) How is the construct of 'insight into offending behaviour' used and understood both by civil servants at the Home Office and RMO's in forensic units in their assessment of restricted patients?
- (2) How is 'insight into offending behaviour' currently being assessed?
- (3) What beliefs do Home Office employees and RMOs hold about 'insight into offending behaviour' and its importance in the assessment of risk?

Method

Qualitative methodology ('framework analysis', Ritchie & Spencer, 1993) was used to explore Home Office caseworker and RMO understanding and use of the construct of insight into offending behaviour and their approach to its assessment in mentally disordered offenders on restriction orders. It was planned to interview ten participants from each profession, and that the RMOs would be recruited across two services willing to participate in the research, thus allowing a wider range of opinion and the opportunity to investigate differences of opinion between settings.

Settings

Participants were recruited from three sites: the Home Office Mental Health Unit in London, and two forensic psychiatric services in North London and South-East England.

Home Office Mental Health Unit

The Mental Health Unit (MHU) is sited within the main Home Office building in Westminster, and employs some 67 staff. Caseworking of patients on restriction orders accounts for a significant proportion of the work undertaken by the MHU, and it employs approximately 46 staff dedicated to this task. Their role is to review correspondence and applications from the RMOs of patients on Restriction Orders.

The unit operates within a hierarchical structure. Caseworking the 4,600 patients currently monitored by the MHU is divided among six teams, each comprising approximately four 'Executive Officers' ('caseworkers') and one Higher Executive Officer (or 'senior caseworker'). Each of these teams is supervised by a 'Senior Executive Officer' and a Casework Manager (or 'Grade seven'). Casework is divided between teams alphabetically, with each team taking responsibility for patients whose surnames begin with particular letters of the alphabet (e.g. A-E). Executive Officers each carry a caseload of approximately 200 cases each, and they undertake the day-to-day work of the unit, reviewing the applications and correspondence from RMOs. They make recommendations according to the information provided before passing this work onto the decision-making grades: either the Higher Executive Officer (for decisions such as repeat leaves or escorted leave) or to the casework manager (for

decisions such as unescorted leave or discharge). The casework manager takes overall responsibility for the collective caseload of workers reporting to him or her (approximately 800 cases). Overseeing the entirety of the MHU's work, and providing guidance for the casework managers in particularly difficult or high-profile cases, are the Head of Caseworking, and then the Joint Heads of Unit.

Forensic Services

RMOs were recruited from two forensic services in South-Eastern England. *Site A* is a medium-secure unit covering seven Greater London boroughs and spanning both inner-city and suburban areas. It offers both mental health and learning disabilities services, both inpatient and outpatient. It provides beds for both mentally ill and learning disabled offenders and employs ten RMOs.

Site B is also a medium-secure unit offering inpatient care and outpatient follow-up for mentally disordered offenders. It provides a mental health service, split across four service areas of equal size (male acute, sub acute, rehabilitation and a single female ward). It spans rural, suburban and urban areas of South-East England, and employs five RMOs.

Ethics

Ethical approval was obtained from the Oxfordshire Research Ethics Committee A, which deemed the study exempt from site-specific assessment and Local Research Ethics Committee involvement (see Appendix 1). In accordance with the procedures specific to each NHS Trust, approval was also gained from the Trust Lead for Research at one of the two specialist forensic services, and from the Chair of the

Research and Development Committee at the other (see Appendix 2). In addition to the usual ethical requirements for research projects, the ethics committee required that the researchers should have in place an agreed procedure for the reporting of any malpractice revealed at interview, and for this to be made transparent to potential participants before consent was obtained.

Participants

The initial aim was to recruit equal numbers of RMOs and Home Office caseworkers. In the event, however, it proved difficult to recruit more than five participants at the Home Office due to pressures on their time.

Home Office Mental Health Unit

Potential participants at the Mental Health Unit were identified by a research contact at the Home Office, who worked within the unit. He provided his colleagues with information about the study's aims and objectives, and arranged meetings for the researcher with interested caseworkers. Five members of staff responded positively to the request for help with the research. Background information on these participants is given in Table 1.

All five participants worked in the senior parts of the MHU hierarchy. The main contact at the Home Office said that it was not possible to recruit junior staff due to their extensive workloads.

In addition to the five participants recruited from the caseworking staff, one of the Joint Heads of Unit was also interviewed. She was not directly involved in the day-to-day casework, but oversaw this work and was involved in high profile and difficult cases. Data resulting from her interview provided the researcher with general contextual information about the unit's work, but was not included in the analysis as she could not provide specific information relating to the research questions.

Forensic Services

RMO participants at both sites were recruited via an email which was sent to all RMOS at each site by members of the research team who also worked at the services.

Table 1: Demographics and professional history of MHU participants

Gender	Age Range	Ethnicity	Years caseworking	Professional background
Female	40-44	White British	9	Prison service
Male	35-39	Dual (White British/ Indian)	6	Law, criminology
Male	40-44	White British	2	Prison service
Male	45-49	White British	3	Home Office
Male	Missing	Missing	Missing	Missing

Note that participants' ID numbers and staff grades have been omitted here to preserve confidentiality.

The right to refuse to participate was emphasised at this early stage in recruitment at both sites. RMOs who were interested in participating contacted a member of the research team.

Eleven RMO participants were recruited across the two forensic psychiatry services, eight from Site A and three from Site B. All eleven were Consultant Forensic Psychiatrists by training. Background information about these participants is given in Table 2.

Procedure

The researcher met with each potential participant to discuss the research and seek informed consent. Participants were given an information sheet and asked to sign the informed consent form (see Appendix 3). Table 2: Demographics and professional history of RMO participants

Table 2: Demographics and professional history of RMO participants

Gender	Age range	Ethnicity	Years employed as RMO
Male	30-44	White British	3
Female	30-44	White Other	4 ½
Male	30-44	White British	2
Male	30-44	White Other	1
Male	30-44	White British	5
Male	30-44	White British	3
Female	30-44	White British	5
Female	30-44	White British	1 ½
Male	45-54	White British	7
Female	45-54	White British	11
Male	45-54	White British	10

Note that participants' ID numbers were omitted here to protect confidentiality.

Participants were then interviewed using a semi-structured interview schedule (see Appendix X). The schedule was designed to prompt discussion of the participants' perceptions of the following areas:

- Home Office requirements in relation to assessment of restricted patients
- specific terms used by the Home Office relating to ‘insight’ and other related constructs
- the process of assessment of insight into offending in the context of risk assessment
- the role and importance of insight into offending in the context of assessment of patients.

The phrase ‘insight into offending’ did not appear on the information sheet or consent forms and was not mentioned in the interview by the researcher until after the participants had been asked about their understanding of risk assessment and their practice of this procedure. This was to enable the researcher to determine whether ‘insight into offending’ was a phrase that was readily used by the participants, and whether it was considered to be a relevant factor in risk assessment.

The interviews were scheduled to last one hour, but ranged between 35 minutes and an hour. They were audio-recorded and subsequently transcribed.

Analysis

Framework analysis (Ritchie & Spencer, 1994) was used to guide data collection and analysis. This is a qualitative methodology developed in the context of applied policy research, which, because of its objective of providing outcomes and recommendations influential to developing policy and legislation, has a set of procedures to demonstrate systematic and visible stages of analysis. The transparency of this analytic approach made it an appropriate research tool to investigate this area of forensic assessment.

This was both due to the settings in which the research was taking place, and to the potential for the research to influence official guidelines and procedures within a government department as well as clinicians with statutory responsibilities. A further advantage of the approach is its suitability to performing particular functions important to this research project. Relevant functions listed by Ritchie & Spencer (1994) are:

- (1) defining concepts (understanding internal structures)
- (2) mapping the range, nature and dynamics of phenomena
- (3) developing new ideas, theories and strategies.

The visibility of the analytic procedure in Framework Analysis also aids the establishment of both the validity and credibility of conclusions drawn from the data, and lends itself to the fulfilment of the 'good practice' guidelines for qualitative research described by Elliott, Fischer & Rennie (1999).

The data were divided into MHU transcripts and RMO transcripts and analysed separately in order to facilitate the comparison of data provided by the two groups and to maximise the chances of independent analysis of both sets of data. In accordance with the methodology, the researcher familiarised herself with the transcribed data through repeated readings. Key ideas and recurrent themes were listed and a sense of the range and diversity of the data was gained at this stage. A thematic framework which identified key issues, concepts and themes was then developed for each group (see Appendix 6). Each transcript was then re-examined and the data referenced according to the framework (see Appendix 7). Data were then 'charted' – extracted and sorted according to identified themes – thus making explicit the range of attitudes

and ideas expressed (See Appendix 8). Analysis culminated in the production of six charts (three for each of the participant groups, reflecting the three main themes). Appendix 8 illustrates this charting process for theme 2 (described in the results section below). These charts were then used to identify and scrutinise characteristics and patterns within the data in the final part of the analytic procedure.

Validity Checks

Although data collection and analysis were conducted by the principal researcher, issues pertaining to validity and reliability were considered throughout the research process. Owing to the work commitments of many of the participants and their concerns that their involvement in the study should not exceed the hour-long interview described in the information sheet, it was not possible to obtain testimonial validity data (Mays & Pope, 2000). However, in accordance with the broad principles for good practice in qualitative research discussed by Elliott et al. (1999), the research team acted as 'auditors' of the work in progress. Transcripts were read by two other members of the research team, and throughout the analytic procedure (the development of the frameworks and the indexing and charting of data) regular meetings between the researcher and these colleagues allowed discussion about interpretation and grouping of data and established consensus across researchers. Furthermore the clarity of the framework methodology (with its explicit display of data, its categorisation and integration), aided in particular the fulfilment of the transparency and coherence principles advocated by Elliott et al. (1999), Yardley (2000) and Mays & Pope (2000), which contribute towards establishing validity (see Appendix 6).

Position of researcher

The researcher was a white trainee clinical psychologist in her late twenties. She was not aware of any preconceived ideas about insight into offending behaviour or its importance to the risk assessment procedure, having never worked clinically within a forensic setting nor having had previous contact with the Home Office MHU. Within her own clinical practice, the researcher's main theoretical approaches to assessment and treatment were psychodynamic and cognitive behavioural.

Results

Five Home Office Mental Health Unit caseworkers and eleven RMOs were interviewed. The analysis generated three key themes (see Table 3).

The term 'insight' in this section refers to 'insight into offending behaviour' unless otherwise stated.

Table 3: Interview data: themes and sub-themes

Theme	Sub-themes
1. Insight in risk assessment	1.1 Relevance of insight to risk assessment 1.2 Insight and rehabilitation
2. Definitions of insight	2.1 The cognitive-behavioural model 2.2 Moral reasoning: acceptance, understanding and remorse 2.3 Appreciation of the personal consequences of the offence (Caseworkers only) 2.4 Compliance with care team's understanding

(RMOs only)

2.5 Insight is dynamic (RMOs only)

3. Assessment of insight

3.1 Behavioural assessment of insight

3.2 Insight can be assessed conversationally

3.3 Insight is demonstrated by verbal and behavioural consistency

3.4 Assessment of insight is more difficult depending on diagnosis (Caseworkers only)

3.5 Psychometric assessment of insight (RMOs only)

Theme 1. Insight in risk assessment

This theme describes the role, if any, that participants thought insight had to play in risk assessment and its relative importance within that process.

1.1 Caseworkers' views on the role of insight in risk assessment

1.1.1. Relevance of insight to risk assessment

Two caseworkers listed insight as a consideration in risk assessment and sought evidence of it when evaluating an RMO's application or report:

'We're looking at risk assessment. So we're looking for any information.. that will help us do that. So things like... insight into the offence, ..insight into their illness.. so if it was drug-induced psychosis, you'd be looking for.. an indication.. that the patient understands the link between the drug abuse and mental illness.' (HOCW2, p10)

These caseworkers also considered the patient's ability to empathise when assessing risk – a factor they both included in their definitions of insight later in their interviews.

Three caseworkers did not mention insight. Although two of these listed evidence of the patient's ability to empathise as a factor in risk assessment, they did not cite this ability in their definitions of insight later in the interview. These participants' responses generally indicated that when making a risk assessment they were less concerned with analysing the patients' own insight into their behaviour than gaining some insight themselves into what led the patient to behave as they did:

.. particularly one I remember who was a sex offender who'd start with quite small things like flashing at people.. and every offence he committed just got worse and worse and you could see it.. and in the end he just committed the most awful.. offence I've ever read really. And it was as though you could see it was going to happen.. So that, I think: understanding the pattern of offending as much as you can' (HOCW3, p. 28)

1.1.2 Insight and rehabilitation

Two respondents stated that determining the presence of insight was necessary to the risk assessment procedure and for rehabilitation. One of these had not initially identified insight as a component of risk assessment. However, both stated the belief that there was a direct and clear relationship between the presence or absence of insight and the risk of re-offending:

‘If they have no insight, the likelihood of them replicating the index offence is going to be massively increased, just simply because they don’t know any better.. you’re not looking at someone who is able to rationalise what they’ve done. So we’re looking for that kind of insight basically, before we can even consider a leave’ (HOCW2, p64)

One participant (who had previously expressed the view that insight was not always necessary in this context) elsewhere expressed contradictory views similar to those described above:

‘If you’ve got someone who has committed a sexual offence and they’ve got no insight into the sexual offence and the factors behind it then yes, I would link that quite heavily to saying no to something.. (HOCW1, p93)

In contrast, three caseworkers thought that although determining the presence or absence of insight could be relevant to risk assessment, it was not necessary for rehabilitation. They provided various reasons for this. Two stated that insight was of less interest to them than control of the mental illness when offences had been committed in this context:

‘I think if they’ve got insight it’s better. But it’s not a veto if they haven’t.. a lot of our patients never take responsibility for the offence and they’re out in the community.. because.. the assessment is that they offended because of their mental illness and their mental illness is under control’ (HOCW1, p50-53)

One of these caseworkers stated that insight was of more importance when assessing patients with diagnoses of either personality disorder or psychopathy:

‘I think it’s trickier sometimes with PD. I mean there you are looking in a purer sense into insight into a certain offending behaviour.. about why they did something and what.. they are doing to overcome why they did it and what insight they detected into their behaviour...’ (HOCW1, p91)

‘Psychopathic disorder, I think, is more complicated.. I think there you are starting to look for more insight into what they’ve done’ (HOCW1, p44)

Two respondents, including one of the above, stated that establishing insight was neither fundamental to risk assessment nor necessary for rehabilitation because it was not always possible:

‘.. insight is just one part of the picture. There are patients who never get insight, but that doesn’t mean they can’t be rehabilitated’ (HOCW4, p29)

1.2 RMOs’ views on the role of insight in risk assessment

1.2.1 Relevance of insight to risk assessment

Five RMOs mentioned insight when describing how they assessed. Two others listed other internal processes related to insight. RMO 6 cited ‘insight into the need for treatment’, ‘attitudes towards the offence’ and the patient’s ability to empathise, the

latter of which formed part of their definition of insight. RMO 10 also cited 'current attitudes towards the offence', although their definition of insight did not include the patient's attitudes or feelings about the offence.

The remaining four RMOs did not include any factors specific to patients' internal worlds (i.e. thoughts about the offence and attitudes or emotional responses towards it). Instead their practice in risk assessment was to consider observable behaviours as well as the views of others involved in the patients' care or personal life.

1.2.2 Insight and rehabilitation

Six RMOs believed there was a clear link between insight into offending and recidivism and that it was therefore necessary in risk assessment and for rehabilitation. However, only one of these participants suggested that this applied in all situations:

Interviewer: Do you link offence-related insight to the risk of re-offending..?

RMO2: Yes! ..if an individual has little understanding – insight, awareness, whatever – into an offence .. then there is every possibility that the circumstances of that offence will be repeated.. so that they'll end up in a similar offending situation'

(RMO2, p33)

The remaining five cited situations where this might not be the case, suggesting that there was not a straightforward relationship between insight and risk.

The majority of RMOs (eight) expressed a pragmatic view of the importance of insight in the context of risk assessment and the prediction of recidivism. They maintained that whilst the assessment of insight was relevant to this procedure, it was not the most important factor and even not necessary. Seven stated that this was because insight was not always possible:

‘There are some patients (who).. can neither give a clear account of their offence or their mental state at any point.. that’s not to say those.. patients shouldn’t make progress, because they might be able to take leave and live in the community and not pose a risk to anybody because the actual risk factors.. ... aren’t... there. So I don’t think it’s ever essential that someone has good insight into their offence.’ (RMO4, p16-17)

Some listed specific reasons why the achievement of insight might not be possible for patients. These were: cognitive deficits due to learning disabilities (1 RMO), amnesia for the time of the offence (2 RMOs), a diagnosis of personality disorder (2 RMOs), and a diagnosis of Asperger’s syndrome (1 RMO). One RMO argued that the achievement of insight is too difficult for most people – non-offenders and offenders alike, and therefore it is unrealistic to expect patients to demonstrate it:

‘Insight has something to do with the ability to stand back and look at yourself, as if from the outside. Patients find that hard.. and you can see why because we all do.. We have to be realistic about insight.. a reason it’s not so important is that it’s not really that achievable.’ (RMO8, p24)

Three respondents who argued that establishing insight was of limited value in risk assessment gave the reason that it was possible to have insight and re-offend. This could be due to limited resistance to 'triggers' (e.g. alcohol), or indifference to the harm caused by the offence. These respondents' views are described fully elsewhere (see section 3.2.2).

This pragmatic view of insight was implied even where RMOs had not specifically articulated the views described above. The greatest consensus amongst RMOs was the belief that externally observable factors were most relevant. Ten described the presence or absence of 'risky', 'inappropriate', 'irresponsible' or violent behaviours as fundamental to their assessment of risk. The next most common factors were observed stability of mental state (six RMOs) and the use of drugs and alcohol (six RMOs).

For a significant proportion of RMOs (seven), evidence that risky symptoms or behaviour were under control was of more importance than evidence of insight. Six of these were primarily concerned with the patients' current mental state:

'Say someone with schizophrenia.. they could be on depot medication, psychosis could be well-maintained, and even though they.. fail to develop insight into their offending behaviour, you know they are on a restriction order and you can bring them back if they stop taking their depot and so on...that would slightly outweigh the fact they've failed to develop full insight into their offending behaviour. It's not top of my list' (RMO3, p36)

For two of these seven, the various forms of external controls around the patient were of significantly greater relevance. These ‘controls’ were either aspects of the forensic system (e.g. restriction orders, secure units) or those organised by community services (e.g. monitoring by mental health and social care agencies):

‘I wouldn’t only.. discharge.. patients who had complete insight.. there are other support mechanisms that can be put in place to.. reduce the risk of them re-offending.. Having complete insight is (not) .. mandatory (for).. discharge.. because we wouldn’t be discharging quite a lot of our patients if that were the case.’ (RMO9, p39-40)

1.3 Theme 1: Summary of views

Caseworkers and RMOs were divided in terms of how salient insight was in their thinking about risk assessment. A greater proportion of RMOs than caseworkers mentioned the construct or related terms without prompting. For a minority of RMOs, the cognitive elements of risk assessment, including insight, were clearly not at the forefront of their minds. Their responses focussed solely on behavioural evidence of risk. Most caseworkers were more concerned with their own understanding of the offence than with patients’ understanding.

Whilst all participants agreed that insight into offending could play a role in risk assessment, they varied in terms of the importance they placed on it. There were a variety of views expressed, both between and within interviews. The majority of both RMOs and caseworkers expressed the view it was neither the most important factor, nor necessary for rehabilitation. Most of these believed that control of the patient’s

symptoms and/or contact with ‘triggers’ contributing to offending was more important. A minority of caseworkers and a majority of RMOs also conveyed pragmatism in relation to their expectations of patients’ ability to achieve insight. A minority of RMOs additionally doubted the importance of insight in reducing risk of re-offence.

On the other hand, a substantial proportion of participants believed insight was a key element of risk assessment and was necessary for rehabilitation, although only one RMO stated this unequivocally. The remainder either did not express this view in the first place, or qualified or contradicted themselves later in their interviews. Amongst the RMO group there appeared to be more complexity of opinion on this matter, both between and within participants’ accounts.

Theme 2: Definitions of ‘insight into offending behaviour’

This theme describes participants’ understanding of the term insight. These data were determined both from definitions given and what was implied in participants’ descriptions of how they assessed this construct.

2.1 Caseworkers’ definitions of insight

2.1.1 The cognitive-behavioural model

When considering insight, four out of five Home Office caseworkers sought evidence of patients’ understanding of the offence through a model of antecedents, behaviours and consequences. They believed that understanding the components involved in the offence (including the role played by mental illness or disorder) would better equip

patients to avoid identified ‘triggers’ in the future, thereby reducing the chances of recidivism:

‘ It’s.. about whether they understand why it happened in the first place really. . you know, what they could have done or what could have happened (to) ...prevent.. it.. And ideas about how to avoid it in the future’ (HOCW3, p45)

2.1.2 Moral reasoning: acceptance, understanding and remorse

Three caseworkers believed a key element of insight to be expression by the patient of acceptance and understanding of the moral gravity of the index offence:

‘If they remain unaware of the fact that their actions were directly responsible for deaths and pain or whatever then.. they have no insight..(and) they haven’t any awareness of what they did wrong’ (HOCW2, p64)

They also spoke of ‘minimisation’ of the offence as evidence of lack of insight.

Four caseworkers, including these three, sought evidence of empathy for victims and an appropriate emotional response to that empathy, such as remorse (three used this term) or regret, thus demonstrating a belief that such emotional responses indicate reduced risk of re-offence:

‘A lot of them initially do.. minimise the seriousness of the offence.. it is about coming to terms with the offence so broadly it is about insight – understanding what

you've done and the ramifications of it.. so obviously if they are aware of causing lots of pain and suffering and have remorse then they are less likely to, from our perspective, repeat that' (HOCW2, p22)

'(If) they feel remorse about what they've done then it clearly makes the risk more easy to identify and manage. And remorse is a part of insight is a part of a continuum of how the patient is going to respond to treatment and how effective it's going to be in preventing harm' (HOCW5, p12)

One caseworker (HOCW4) did not list any emotive components in their definition of insight, but focussed instead on a rational understanding of the circumstances surrounding the offence.

2.1.3 Appreciation of the personal consequences of the offence

Two caseworkers described the patient's appreciation of the impact that the offending behaviour had had on their own lives as a key element of insight:

'These are the things that show (insight), like they.. understand how.. (the offence) might have affected their own lives.' (HOCW3, p 53)

2.2 RMO's definitions of insight

2.2.1 The cognitive-behavioural model

RMOs generally understood insight to mean that the patient had grasped the RMO/MDT's cognitive behavioural model of the offence and the factors (stressors, triggers, and circumstances) contributing towards its occurrence. Ten RMOs described insight in this way:

'What is their explanatory model for the offence, as it were? And I guess what you think has contributed to the offending, um.. and the extent to which they either do or do not buy into that.' (RMO3, p26)

Eight went further, defining insight as demonstration, through changed functioning, that they have achieved this level of understanding. They believed that having thus understood their past behaviour, application of this model to their current and future circumstances allowed patients to be aware of, and to exert better control over, the factors likely to lead to re-offending:

'Do they know the circumstances in which the offence occurred or the circumstances that were relevant to the commission of the offence?... Do they know how they might control those circumstances so that they don't find themselves in a similar situation in the future?'

 (RMO2, p6)

2.2.2 Moral reasoning: acceptance, understanding and remorse

Eight RMOs considered an important element of insight to be the expression by the patient of some understanding that their offending behaviour had been 'wrong': that it

was both unacceptable and deserving of society's censure. Five explicitly stated that they required evidence from clinical interview that the patient understood the moral gravity of their offence:

'It's about recognising that what they did could or did cause harm to another or themselves.. and also recognising that it is something that shouldn't be repeated in the future... Recognition that they'd done something that was wrong.' (RMO 7, p9-10)

Six RMOs required evidence from clinical interview that the patient accepted personal responsibility for their offending behaviour, and expression of an appropriate emotive response to that acceptance. They described these responses variably as 'empathy' (for the victim), 'guilt' or 'remorse':

'Do they understand they've even committed an offence? Is it even at that level? And the issues of remorse.. and also alongside remorse there's victim empathy.' (RMO 4, p10)

'I think they've got to bare their souls. I think they need to know the impact that the offence will have had and.. understand why you can't commit that sort an offence. You won't get remorse with every patient.. To ask them to step into someone else's shoes, feel that, and then feel sorry for it is something they've never been able to do' (RMO11, p 16-17)

Three of these eight participants also spoke of the need for patients to understand the broader anti-social nature of their actions:

‘How much of a responsibility do they take and how much they accept for their own behaviour and its potential effect.. not only.. on the victim but on the public in general’ (RMO5, p6)

2.2.3 Compliance with care team’s understanding

For six RMOs, acceptance of the multi-disciplinary team’s understanding of the offending behaviour, its precipitating factors, and its relationship with the mental illness or disorder was fundamental to insight:

‘Well.. it’s always easier to think about insight into mental illness, and the three things you are thinking about there are.. can (they) relay symptoms as evidence of a mental illness?.. (Do) they recognise that they have a mental illness, and (do) they.. comply with medication?... Insight into offending behaviour then, um.. it’s the extent to which their model of their offending behaviour concurs with your model...’

(RMO3, p28)

‘So, insight about offending would probably require you first of all.. to have the same understanding of your mental disorder and the role that plays in your offending as the doctor has’ (RMO8, p12)

2.2.4 Insight is dynamic

Three participants described insight as existing on a continuum and its development

as a gradual process:

‘Insight is not a ‘yes/no’ thing, is it? There are degrees of insight. Some patients you feel will only ever achieve a certain amount of insight either into their illness or into the offence.. whereas some seem to regain full insight and some stay pretty insightless’ (RMO6, p18)

‘(One) need(s) to accept that sometimes there are grey areas... I remember one patient who consistently said ‘I didn’t do it’, then it moved to ‘I don’t like to think I’m the sort of person who could have done that’, then to ‘Well, I know I have no memory of it.. (but) I’ve got to accept that (it) did actually happen, and it must have been awful for them’. That’s the sort of pattern you’ll see.’ (RMO11, p14)

One of these expressed the additional view that insight is dynamic – that patients can sometimes ‘have’ insight and at other times be without it:

‘I suppose people are capable of insight and they are capable of transient insight.. the Home Office would like there to be something solid called insight that you can get hold of. But people can have insight part of the time and then lose it again’ (RMO8, p10)

2.3 Theme 2: Summary of views

The majority of caseworkers and RMOs primarily defined insight as an understanding of the offence through a cognitive-behavioural model of antecedents, behaviours and

consequences. The majority of both groups also considered a key element in insight to be acceptance of the moral gravity of offending and the consequences for victims. In addition, some caseworkers spoke about the patient's understanding of the negative consequences of the offence on the patient's own life, whereas none of the RMOs mentioned this. Instead, some RMOs included in their definitions a grasp of the anti-social nature of the offence. RMOs tended to include more elements than caseworkers in their definitions, additionally citing the acceptance of the MDT's model of offending and willingness to work with this. Some RMOs also spoke of the dynamic nature of insight.

Theme 3: Assessment of 'insight into offending'

This theme describes participants' personal practices in assessing insight.

3.1 Caseworkers' beliefs about assessing insight

3.1.1 Behavioural Assessment of insight

Four caseworkers described a key component in the assessment of insight as observation of the patient's behaviour:

'So ... if you see something saying 'So-and-so has complete insight'..., and then you read that he or she has been out .. drinking heavily then you know that it's complete rubbish.. There's clear evidence there' (HOCW1, p67)

One of these caseworkers described behavioural evidence of insight in terms of 'responsible behaviour' as opposed to 'changed' behaviour:

'Most of them show by their actions their responsibility.. for example, if they realise that they are mentally ill and that medication helps then insight would be demonstrated by their taking their medication responsibly' (HOCW4, p29)

3.1.2 Insight can be assessed conversationally

Two participants assessed insight through appraisal of how 'genuine' the patient sounded in statements from clinical interview that were cited by RMOs in their reports. They felt it was possible to be familiar enough with patients from the paperwork they received regarding them to enable them to make an informed assessment about the 'truth' behind their quoted conversation:

'They seem to say things that sound very clinical.. and it sounds as though it's not things they normally would have said. Because once you've got a feel for a patient and the sorts of things they say.. because they are quoted in reports - .. word for word. If the insight sounds like something they've.. read in a book, and it does sometimes.. quite often you can tell'
(HOCW3, p67)

3.1.3 Insight into offending can be assessed by verbal and behavioural consistency

Two caseworkers were less concerned with the apparent sincerity of what patients said than in evidence of consistency. They wanted to see them expressing the same kinds of thoughts and feelings about their offences over a period of time and with different members of staff – as well as behaving in a consistent manner - in order to consider that they had achieved true insight:

‘If we had a consistent assessment that somebody’s insight was this and progressing along this line and it appeared to be coherent and all come together then fine – there would be no problem.. If you have somebody who.. (has) been a real management problem.. and then suddenly you get a new RMO who turns around and says ‘No, he’s fine.. he’s got insight’, then you might be a bit bothered’ (HOCW5, p20)

3.1.4 Assessment of insight is more difficult depending on diagnosis

Three caseworkers thought that certain mental disorders rendered the assessment of insight more difficult. Two considered psychopaths to present particular problems, believing they were more likely to deceive clinical staff and present ‘false insight’. One of these, and one other participant, also considered patients with personality disorders to present similar difficulties for assessors:

‘We don’t always know whether a patient’s insight is learned [as opposed to ‘real’]... With people who are suffering from personality disorder or psychopathic disorder.. very bright people in the main – .. they’d be able to learn insight or at least the expression of insight and the good it can do them’ (HOCW4, p33)

3.2 RMOs' beliefs about assessing insight

3.2.1 Behavioural assessment of insight

Behavioural assessment was the most often cited means of determining the presence or absence of insight. All but one RMO stated that they assessed insight, in part at least, through monitoring a patient's behaviour both in hospital and on leave. They wished to see demonstration of patients' understanding of the factors contributing to their offence through evidence of changed functioning:

'(Does) the patient practice what they say? Do they exhibit on the ward or ground leave what they say in therapy and clinical interview?.. As a patient gets.. more freedom it is easier to see whether they have true insight and whether they've applied this insight to their dealing with situations, demonstrating they've learned from what's happened ' (RMO10, p2)

Eight RMOs saw a patient's compliance with the multi-disciplinary team as behavioural evidence of the presence of insight. Specifically, they spoke about compliance either with treatment or with the care team's model of their offending and the therapeutic work based on it as evidence of insight:

'Are they co-operating with the treatment plan? I mean, that's always relevant when assessing insight because, you know, if they're not then clearly they have no insight' (RMO2, p9)

‘Interviewer: So it sounds like.. you draw up a model of how the offending came about, and then it’s about the patient agreeing with that?’

RMO11: Thinking about what it must be like for the patient, I think that it probably is. It’s about them agreeing to go along with that model.’ (RMO11, p24)

Three RMOs, including two that had previously stated the importance of behavioural observation in assessment of insight, expressed the opinion that behavioural assessment of insight was an inaccurate means of evaluation. Two of these argued that a patient could ‘have’ insight and yet still engage in risky or offending behaviour. They implied that observation of the ‘changed functioning’ sought by their colleagues as evidence of insight in fact demonstrated the successful practice of will power:

‘You can be perfectly insightful into your offending behaviour, and still continue to offend... you can understand what drives you to, say, sexually assault someone without being able to stop the cycle leading to the assault’ (RMO3, p28-31)

‘A patient might say that they won’t go into a pub when they are on leave - if drinking has been a component in the offending behaviour - but like the rest of us if they are pissed off and thirsty the reality is different. Does that mean they don’t understand or they haven’t learned from the past? I guess that’s how insight is more complicated than just ‘the patient knows x, y and z contributed to the offence and they show this by avoiding x, y and z’’ (RMO8, p18)

The third RMO noted that it was possible for patients to be insightful yet indifferent about past behaviour and so re-offend despite their understanding:

‘If someone has insight.. they might understand why they rob banks but they might choose to do it. So it’s not always a positive thing.. (RMO4, p47-48)

3.2.2 Insight can be assessed conversationally

Eight RMOs assessed insight, at least in part, through ‘intuitive’ judgement about patients’ level of insight and the sincerity of their expression of it in clinical interview:

‘I think you’d have a sense of whether it’s a learned response, or whether it (has).. some sort of meaning... it’s kind of intuition - and clinical experience. I don’t think it’s anything more scientific than that’ (RMO3, p37-68)

‘It’s pretty easy to know when it is learned – if you are really trying to find out, by challenging the patient.. I think you can tell if people are just using words that (they) are not clear of the meaning of’ (RMO8, p12)

3.2.3 Insight demonstrated by verbal and behavioural consistency

Five RMOs sought evidence of consistency of non-risky behaviour when assessing insight, as well as the consistent expression of attitudes and sentiments suggestive of insight both with different members of staff and across a significant time period:

‘It is demonstrated over time in how they.. respond to individual sessions they are having with various members of the.. team, whether what they say to one person is what they say to another... it’s the way they are continually assessed and reassessed and hopefully that would highlight problems.. (it’s) how they are responding and what their behaviour is like’ (RMO9, p12-13)

Two other RMOs agreed that the impressions formed by members of the multi-disciplinary team were important in establishing whether or not the patient had achieved insight.

3.2.4 Structured assessment of insight

A small minority (two RMOs) argued that in addition to clinical interview, there was a place for psychometric assessment in the assessment of insight. One of these mentioned the potential role of the HCR-20 and one the Hare Psychopathy Checklist – Revised (Hare, 1991, 2002):

‘Sometimes it’s relevant to use psychometric tools. For example, if we feel someone has a personality disorder then a formal assessment.. using empirical tools is helpful. We have recently started.. using the HCR-20.. for the assessment of risk’ (RMO2, p7)

‘There can be a role for psychometrics in this.. the PCL-R (Hare Psychopathy Checklist – Revised) might have some role, but a limited one.. It can be a way of

identifying if they are just going through the motions or not, but the scores can ‘stick’, so use it sparingly. It’s best done clinically’ (RMO10, p2)

3.3 Theme 3: Summary of views

The majority of caseworkers and RMOs assessed insight behaviourally, seeking evidence of understanding of the offence through changed behaviour and/or compliance with treatment plans. Three RMOs, however, observed that behavioural assessment could provide an inaccurate evaluation of insight because continued displays of risky behaviour did not necessarily indicate lack of understanding.

A minority of caseworkers and the majority of RMOs considered a central part of assessment to be ‘intuitive’ analysis of the patient’s expression of insight either in clinical interview (in the case of RMOs), or on paper (in the case of caseworkers). Participants in both groups (and the majority of RMOs) also believed that insight could be determined through monitoring the consistency of patients’ behaviour and expressed attitudes across time, staff and settings. Some RMOs also mentioned the use of psychometrics in some circumstances.

Discussion

This paper set out to initiate discussion about ‘insight into offending behaviour’ and to develop understanding of this construct and its place in forensic risk assessment. It uses the example of the current British system of managing mentally disordered offenders but proposes that these findings are of wider significance. The research described here was necessarily limited in terms of settings and numbers of

participants involved, but it has provided some important starting points for further investigation. Most importantly, it has confirmed that the 'insight into offending behaviour' construct is meaningful to those involved in decision-making in forensic psychiatric risk assessment and in currency both within psychiatric services and the British civil service despite being poorly defined. Almost half the participants (seven out of sixteen) mentioned insight spontaneously in the context of risk assessment and the remaining nine did not query the term and were able to engage fully in discussion about its meaning and assessment. This indicated that all participants had some kind of personal model of insight. All understood the phrase to refer to something relevant to risk assessment despite the generally held belief that other factors were more important in the decision-making process. However, even within this relatively small sample there was considerable diversity of opinion about insight, its assessment and its importance.

Noted differences in understanding of insight and its role in risk assessment shows that participants held a number of working models of insight. The fact that many participants expressed different views even within their own accounts suggested that these respondents were not working with explicit models or definitions. The contradictory responses of some participants and the subsequent qualification of points made suggested that many were unaware of their own lack of clarity about this construct until specifically asked to think about it as research participants. It was possible, however, to identify some of the implicit models and assumptions that were being used as a framework for understanding insight.

Since cognitive-behavioural theory is at the base of treatment models in most forensic settings (including work specifically aimed at developing insight), it is perhaps not surprising that a common definition of the construct amongst both groups appeared to be based on the patients' acceptance and understanding of a cognitive-behavioural model of antecedents, behaviours and consequences relating to the offence. This treatment model, which lies at the root of many psychology-run offender programmes, aims to change behaviour by helping patients counter destructive automatic behavioural responses with an 'objective' awareness of their thinking patterns and how to control them. Although the word 'insight' is not explicitly used to describe the goal of these programmes, it seems that the cognitive-behavioural model has been influential for many professionals in the development of their personal models of the insight into offending construct. Exactly how this cognitive-behavioural 'self-awareness' and the insight construct relate, however, remains unknown, as does the question of how widespread this belief in their relationship is within the forensic psychiatric community and among caseworkers in general.

The prevalence of research relating to insight into mental illness over the past few decades was clearly influential to participants' conceptualisations of insight into offending behaviour. RMO3, for example, applied a well-known model of insight into psychosis (David, 1990) to insight into offending behaviour (see section 2.2.3). It seems likely that the accepted clinical relevance of the term 'insight' in the context of mental illness within the psychiatric community is responsible, to some extent at least, for assessors' confident assumption that they understood what 'insight into offending behaviour' referred to and how it should be assessed. Indeed, the majority of participants either referred to the two types of insight interchangeably or explicitly

described them as inseparable – practices which suggest implicit use of some of the multi-dimensional models of insight into mental illness (e.g. Amador, Strauss, Yale & Gorman, 1991), in which insight into offending behaviour might be considered to be part of insight into mental illness.

The range of views about insight into offending and its assessment in this study seems to echo the lack of consistent definition of insight evident in the insight in mental illness research. In that field, studies define insight variably, with some primarily focussing on specific factors such as acknowledgement of illness and/or the need for medical treatment (e.g. Bartko, Herczeg & Zador, 1988; Lin, Spiga & Fortsch, 1979) whilst others broaden the concept to include a number of components (Amador et al., 1991; Beck, Baruch, Butler, Steer & Warman, 2004; David, 1990). The responses of this sample suggest that such variability in definition and assessment focus may also exist in the wider forensic psychiatric community for insight into offending behaviour. It might be hypothesised that if such diversity of thought continues to exist in the field of mental illness insight, where there have been few solid conclusions as to its nature and assessment despite twenty years or so of research (Markova, 2005), similar diversity must exist in the forensic psychiatric community's understanding of insight into offending behaviour and clinical practices relating to it. Research leading to standardisation of both definition and assessment practices therefore must also be urgently required in this area of psychiatric assessment.

A related issue evidenced by this study is the apparent practice, despite the ongoing uncertainty described above, of application of assumptions about the relationship of mental illness insight to other clinical variables to insight into offending behaviour.

These appear to be fundamental to some of the implicit models of the construct currently in use. One such model might be termed the 'compliance model'. A number of both RMOs and caseworkers stated or implied that concurrence with the care team's understanding of the offending behaviour and adherence to prescribed treatments indicated the presence of insight into offending. It is interesting that this belief was so prevalent in this group, considering the inconclusiveness of research about the relationship between compliance and insight in the mental illness insight field. There, research has been difficult to interpret partly due to the difficulty in evaluating treatment adherence itself (McEvoy, 1998). Empirical evidence suggests that measuring insight into mental illness by articulated attitude to illness and/or treatment is flawed because it does not necessarily relate to treatment-related behaviours (e.g. Goldberg, Green-Paden, Lehman & Gold, 2001). This finding is presumably of even more relevance in the assessment of insight into offending, where observed attitude and behaviour within the forensic setting appear (according to this sample at least) to be the main means of assessment of post-discharge risk of the patient to the public. The relationship between insight into offending and compliance requires clarification and further analysis. It may also be that the two forms of compliance spoken about by respondents in this study – compliance with medication and compliance with behavioural conditions, which may include, for example, relapse prevention plans – relate differently to insight into offending. Equally, the assumption on which this model is based – that compliance of either kind means a reduction to the risk of re-offence – remains to be proved.

A further implicit model reflecting another widely held belief about insight into mental illness was that which links the presence of insight into offending behaviour to

a good prognosis. This was suggested by the number of both RMOs and caseworkers who considered evidence of insight into offending to be indicative of a reduction of risk and therefore necessary for rehabilitation. Research in the insight into mental illness field has yielded variable results in relation to this question, meaning that the relationship between insight and prognosis, both in terms of direction and strength, cannot yet be determined (Markova, 2005). The prevalence of the assumption amongst participants in this study that there is a positive relationship between insight into offending behaviour and prognosis highlights a further area where evidence from the insight into mental illness field makes an even more compelling case for empirical investigation.

Another important area for further research is the role that moral reasoning and/or 'emotional' insight might play in insight into offending. It is interesting that so many caseworkers and RMOs considered social and emotional processes such as 'acceptance' of the severity of their offending, empathy, remorse, and regret to be integral to insight and believed evidence of these cognitions to be important in the rehabilitative process. Whilst in the past it has been argued that there is a clear clinical rationale for assuming that empathy deficits are an important factor in predicting offending behaviour (Prentky, 1995), recent research has shown that this varies between offender groups (Hanson, 2003; Mulloy, Smiley & Mawson, 1998). The present study, however, revealed that many RMOs and caseworkers held beliefs about the importance of patients 'feeling' their insight (appearing to emotionally 'suffer' as a consequence of understanding their offence and the behaviours and thoughts that preceded it). It is interesting to consider how much of this 'need' for evidence of emotional suffering stems from assumptions about the relationship between

remorse/empathy and recidivism and how much from participants (possibly unconsciously) reflecting the wider community's desire for remorse as a token of reparation (Scheper-Hughes, 1999). It is also interesting to consider how these social and emotional processes are being assessed.

This state of uncertainty surrounding assessment procedures for insight into offending behaviour, or cognitions believed to be part of it, was a key finding in this study. A particularly important finding was the reliance of many RMO participants on clinical 'intuition' or judgement. Interview data revealed a prevalent belief among RMOs in their ability to detect insincerity in patients' discourse in clinical interview and form a judgement about how 'real' their understanding of their offending behaviour is. It is interesting that some caseworkers' view that it is possible to know a patient from paperwork well enough to be able to make a judgement about sincerity of expression seems to mirror this RMO belief. There was also evidence of uncertainty concerning the role of psychometric assessment in the assessment of insight into offending, with some RMOs mentioning it and the majority not. It is possible that both groups relied so heavily on such personal methods of analysis because this whole area of forensic risk assessment remains so nebulous. How clinically useful such personal detection of 'truth' is in establishing the presence or absence of insight into offending behaviour and how likely it is that an offender will re-offend, however, are questions for future investigation. Equally, it would be interesting to determine the nature of such decision-making processes.

This paper has identified one part of the assessment of mentally disordered offenders about which there is no consensus within the forensic psychiatric community. The

validity and generalisability of this research is clearly limited by the relatively small number of participants. Larger scale research is needed to further demonstrate that these findings are both credible and widely relevant. However, these findings indicate that the definition, assessment and clinical relevance of the construct 'insight into offending behaviour' all require investigation. An implicit relationship between risk of recidivism and insight into offending has been shown to exist in the mind of these participants although nothing is known about the direction or strength of this relationship. Assumptions, non-standardised use of existing knowledge from other fields of psychology and psychiatry and personal judgements have all been shown to play a part in assessment process, and lack of clarity of thinking as well as stark differences between understandings and assessment procedures are evident. Further diversity in definition and assessment of the construct probably exists in the wider criminal justice system. Certainly UK parole board documentation refers explicitly to the construct (Parole Board, 1997). Considering the heavy reliance on both established psychological theory and clinical expertise in the generation of personal definitions of insight by the participants in this study, it is interesting to consider how those outside the forensic psychiatry risk assessment process might conceptualise insight.

Forensic risk assessment is a complicated and difficult process that has clear consequences for both public safety and patients' welfare and civil liberties. It is therefore essential that the clinical variables considered in the decision-making process should be accurately and reliably assessed, and that the whole process is standardised. Insight into offending behaviour is one such variable that is not

supported by ‘evidence and rigorous analysis’ (NHS, 2006). It is hoped that that this paper will prompt further research into this aspect of the risk assessment of offenders.

References

- Amador, X.F., Strauss, D.H., Yale, S.A., & Gorman, J.M. (1991). Awareness of illness in schizophrenia. *Schizophrenia Bulletin*, 17, 113-132.
- Andrews, D., & Bonta, J. (2003). *The Psychology of Criminal Conduct*. (3rd ed.) Cincinnati, Ohio: Anderson Publishing Company.
- Arboleda-Forez, A., Holley, H. & Crisanti A. (1998). Understanding causal paths between mental illness and violence. *Social Psychiatry and Psychiatric Epidemiology*, 33, Supplement 1, S38-46
- Bartko, G., Herczeg, I. & Zador, G. (1988). Clinical symptomatology and drug compliance in schizophrenic patients. *Acta Psychiatrica Scandinavica*, 77, 74-76.
- Beck , A.T., Baruch, E., Balter, J.M., Steer, R.A. & Warman, D.M. (2004). A new instrument for measuring insight: the Beck Cognitive Insight Scale. *Schizophrenia Research*, 68, 319-329.
- Blumenthal, S. & Lavender, T. (2001). *Violence and Mental Disorder: A Critical Aid to the Assessment and Management of Risk*. London: Jessica Kingsley Publishers.

Bush, J. (1995). Teaching Self-risk Management to Violent Offenders. In J. McGuire (Ed.), *What works: Reducing re-offending. Guidelines from research and practice* (pp. 139-154).

Crichton, D. (2004). Risk Assessment. In A. Needs & G. Towl (Eds.), *Applying Psychology to Forensic Practice* (pp.64-81). Oxford: Blackwell.

David, A.S. (1990). Insight and psychosis. *British Journal of Psychiatry*, 156, 787-808.

Dent, S. (1997). The Home Office Mental Health Unit and its approach to the assessment and management of risk. *International Review of Psychiatry*, 9, 265-271.

Dolan, M. & Doyle, M. (2001). Violence risk prediction. Clinical and actuarial measures and the role of the Psychopathy Checklist. *British Journal of Psychiatry*, 178 (1), 84-85.

Doyle, M. & Dolan, M. (2006). Predicting community violence from patients discharged from mental health services. *The British Journal of Psychiatry*, 189, 520-526.

Elliot, R., Fischer, C.T., & Rennie, D.L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, 38, 215-229.

Gardner, W., Lidz, C.W., Mulvey, E.P. & Shaw, E.C. (1996). Clinical versus actuarial predictions of violence of patients with mental illnesses. *Journal of Consulting and Clinical Psychology*, 64 (3), 602-609.

Goldberg, R.W., Green-Paden, L.D., Lehman, A.F., & Gold, J.M. (2001). Correlates of insight with serious mental illness. *Journal of Nervous and Mental Disease*, 189, 137-145.

Gray, N.S., Hill, C., McGleish, A., Timmons, D., MacCulloch, M.J. & Snowden, R.J (2003). Prediction of violence and self-harm in mentally disordered offenders: a prospective study of the efficacy of HCR-20, PCL-R, and psychiatric symptomatology. *Journal of Consulting and Clinical Psychology*, 71 (3), 443-51.

Hanson, R.K. (2003). *Stable and acute risk factors in community supervision*. Paper presented at the 13th Annual National Organisation for the Treatment of Abusers Conference, Heriot-Watt University, Edinburgh, 24-26 September.

Hare, R.D. (1991). *Hare Psychopathy Checklist-Revised (PCL-R)*. Toronto, ON: Multi-Health Systems.

Hare, R.D. (2003). *Hare Psychopathy Checklist-Revised (PCL-R)*. (2nd ed). Toronto, ON: Multi-Health Systems.

Hart, S. D., Kropp, P.R., Laws, D.R., Klaver, J., Logan, C., & Watt, K.A. (2003). *The Risk for Sexual Violence Protocol (RSVP): Structured Professional Guidelines for*

Assessing Risk of Sexual Violence. Burnaby, British Colombia: Simon Fraser University, Pacific Psychological Assessment Corporation & The British Colombia Institute Against Family Violence.

Lin, I.F., Spiga, R., & Fortsch, W. (1979). Insight into adherence to medication in chronic schizophrenics. *Journal of Clinical Psychiatry*, 40, 430-432.

Markova, I. (2005). *Insight in Psychiatry*. Cambridge: Cambridge University Press.

Mays, N. & Pope, C. (2000). Qualitative research in health care: assessing quality in qualitative research. *British Medical Journal*, 320, 50-52.

Mental Health Act (1983). In Department of Health (1998), *Code of Practice to Mental Health Act 1983*. London: HMSO.

Mulloy, R., Smiley, W.C., & Mawson, D.L. (1999). The impact of empathy training on offender treatment. *Focus on Corrections Research*, 11, 15-18.

McEvoy, J.P., Apperson, L.J., Appelbaum, P.S., Ortliip, P., Breckosky, J., Hammill, K., Geller, J.L., & Roth, L. (1989b) Insight in schizophrenia. Its relationship to acute psychopathology. *Journal of Nervous and Mental Disease*, 177, 43-47.

McGuire, J. (2000). *Cognitive-Behavioural Approaches: An Introduction to Theory and Research*. M.J.Furniss (Ed.). HM Inspectorate of Probation.

Moody, E., & Snow, P. (2005). Mental Health Unit. *The British Journal of Forensic Practice*, 7 (4), 21-26.

NHS (2006). *Report into the Care and Treatment of John Barrett*. London: NHS.

Powis, B. (2002). *Offenders Risk of Serious Harm: A literature review*. Home Office Research, Development and Statistics Directorate Occasional Paper 81. London: HMSO.

Parole Board (1997). Report of the Parole Board for 1996/7. London: HMSO

Prentky, R. (1995). A Rationale for the Treatment of Sex Offenders: Pro Bono Publico. In J. McGuire (Ed.), *What works: Reducing re-offending. Guidelines from research and practice* (pp. 155-172).

Ritchie, J., & Spencer, L. (1994). Qualitative data analysis for applied policy research. In A. Bryman & R.G. Burgess (Eds.), *Analyzing Qualitative Data* (pp.173-194). London: Routledge.

Ross, R., & Ross, R. (1995). *Thinking straight: The reasoning and rehabilitation program for delinquency prevention and offender rehabilitation*. Ottawa, Canada: Air Training and Publications.

Scheper-Hughes, N. (1999). Undoing: Social Suffering and the Politics of Remorse. In M. Cox (Ed.), *Remorse and Reparation*. London: Jessica Kingsley Publishers.

Srinivas, J., Denvir, S. & Humphreys, M. (2006). The Home Office Mental Health Unit. *Advances in Psychiatric Treatment*, 12, 450-458.

Webster, C., Eaves, D., Douglas, K., & Wintrup, A. (1997). *HCR-20: Assessing Risk for Violence, Version 2*. Burnaby, British Columbia: Simon Fraser University and Forensic Psychiatric Services Commission of British Columbia, Vancouver.

Woods, P., Reed, V., & Collins, M. (2003). The relationship between risk and insight in a high-security forensic setting. *Journal of Psychiatric and Mental Health Nursing*, 10, 510-517.

Woods, P., Reed, V., & Robinson, D. (1999). The Behavioural Status Index: therapeutic assessment of risk, insight, communication and social skills. *Journal of Psychiatric and Mental Health Nursing* 6 (2), 79-90.

Yardley, L., (2000) Dilemmas in qualitative health research. *Psychology and Health*, 15, 215-228.

Home Office documents

Guidance to Responsible Medical Officers: Leave of absence for patients subject to restrictions under sections 41, 45a and 49 of the Mental Health Act 1983 and under the criminal procedure (insanity) acts. (Version dated October 2006). Document produced by the Home Office Mental Health Unit.

Directions to the Parole Board under section 32 (6) of the Criminal Justice Act, 1991:

Release and recall of life sentence prisoners. (Revised directions published 2004).

.

Part 3:

Critical Appraisal

This paper describes how the study described in Part 2 of this thesis came about, and offers a critical discussion of the research process including difficulties that were encountered and how decisions made to overcome these were justified. It also discusses the validity and generalisability of the research and considers how it might have been improved. Strengths and limitations of the study are described and areas for future research discussed.

1. Development of the research question

Plans for this research project evolved following an informal conversation between my external supervisor and a senior member of staff from the Home Office's Mental Health Unit (MHU) at a conference on mentally disordered offenders. My external supervisor had long considered the construct of 'insight into offending behaviour' to be poorly defined, and bearing in mind conversations with clinical colleagues about its use in Home Office documentation guiding Responsible Medical Officers (RMOs) in their assessment of patients under restriction orders, considered it to be an potential area for investigation. Preliminary work for the literature review described in Part 1 of this thesis also confirmed that this was an important area for investigation.

Subsequent communication between the external supervisor and the MHU led to the tentative offer of support for a project investigating this issue. The opportunity for such a collaboration seemed to the research team (external supervisor, two internal supervisors and myself) to present too good an opportunity to miss, especially considering that government departments, including the Home Office, are often perceived by researchers as difficult to access.

Both government departments and professional bodies can often appear to those outside them to operate mysteriously. Staff at the MHU and forensic psychiatrists in the RMO role are two such groups. There is a point of interface in their work in fulfilling their respective roles according to the requirements for the management of mentally disordered offenders laid out in the Mental Health Act (1983). However, they have different training backgrounds, different relationships with patients and services, different roles within the two-part process specified by the Mental Health Act, and different emphases in addressing the challenge of balancing public protection and ethical patient care. Their approach to and assessment of restricted patients can therefore sometimes appear to the other to be confusing or even at odds with their own work. The resulting tension in this relationship has been made explicit in recent years by the publication of a number of papers in forensic journals, both by medics discussing the unit's working practices (Srinivas, Denvir & Humphreys, 2006; Eastman, 2006), and by MHU staff attempting to demystify their work (Dent, 1997; Snow & Moody, 2005). This being the case, we reasoned that, whilst examination of the insight into offending behaviour construct would (in any case) be relevant to the wider forensic psychology and psychiatry communities, research undertaken within this UK-specific context would be all the more valuable for the involvement of both bodies involved in evaluating restricted patients and making decisions about them. MHU support enabled the design of the project described in Part 2 of this thesis.

2. Difficulties encountered during the research process

The involvement of both bodies in decision-making processes about the construct under examination was a strength of the research. However, involvement of an

organisation which was unaccustomed to external scrutiny (the MHU) led, not unexpectedly, to difficulties in the research process and so made some change necessary. These changes raised a number of methodological concerns and posed a threat to the findings' validity and generalisability.

The method of recruitment of participants was the main way in which the research process differed at the MHU compared with the forensic sites. Whilst we easily met the target number for participants at the two forensic psychiatric sites (the intention was to recruit ten RMOs; eleven were interviewed), the process of recruitment at the MHU was more drawn out, more complicated, and ultimately less successful (five participants of the ten originally planned were recruited). The forensic psychiatric sites differed from the MHU in that they were places in which academic research was commonplace. It is not unusual for managers or staff at NHS sites to be approached about participating in research projects, and the language used in describing and justifying research processes was both familiar and understood in these environments. Therefore medical staff were comparatively more receptive to participating in the study. In addition, many of them had at least some understanding of the processes involved.

The comparative reticence of the MHU provoked us to speculate that the unit's management was perhaps anxious about possible outcomes of the study. Certainly negotiation with them at each stage of the research process was a more complicated affair. There were several ways in which this reticence manifested itself. Firstly, the contact person appeared to want more control over the recruitment process than we had planned. Rather than giving me permission to write to all caseworkers to explain

the study and invite them to participate (the planned recruitment method), he preferred to approach particular staff himself. He explained that he would select the staff who he thought would be more articulate about the issues involved. These were all relatively senior staff in the unit's hierarchy and it seemed that MHU management preferred these staff members to represent the unit's position. The contact person was able to recruit five participants in this way, and was reluctant to seek out further participants. My attempts to explain the reasoning behind the intended research process (the validity, reliability and generalisability issues as well as qualitative research theory) were not successful. The contact person expressed the view that it would not be necessary for me to interview more than five members of staff because the MHU had 'a corporate approach' and there was little difference in staff's thinking and approach to their work. Following discussion with the research team, I decided not to push conversation further in relation to these issues. I was very grateful that the unit was supporting the research despite enormous pressures on staff time and did not wish to antagonise. We decided to settle for the five staff who had agreed to participate.

3. Methodological issues raised by difficulties encountered

This issue of the MHU's involvement with the recruitment process obviously raised important methodological concerns. In terms of validity and generalisability it would have been better had I been given free access to the entire caseworker population and control over the way in which they were informed about the study and invited to participate. The fact that this was not possible led to what might be considered weaknesses of the research. Firstly, the sample was fifty percent smaller than had

been planned, thus preventing the intended balance between the RMOs and caseworkers samples outlined in the study design. In addition, the MHU sample was skewed towards seniority and might not be representative of the views of junior staff members who deal with many of the unit's day-to-day decisions relating to casework. Most concerning, however, was the possible accusation of skewed response patterns, due to certain staff members being apparently selected by the MHU contact person.

4. In defence of the findings' validity and generalisability

I do not, however, consider these consequences of the adjustments to the research process to constitute serious limitations for the research. Considering the nature of the population under study – a government department – it is not particularly surprising that these issues were encountered. Indeed, it is perhaps more surprising that the Home Office MHU was willing to take part in the research at all. In addition to the anxiety one might expect in an organisation exposing itself to the scrutiny of outsiders, the Home Office MHU was undergoing a period of considerable change. Three Home Secretaries presided over the Home Office during the years that the research took place and each change was accompanied by understandable upheaval that was apparent in the periodic silences from the unit during my communication with staff there. The Home Office itself came in for highly publicised criticism following the resignation of David Blunkett MP and investigation of the department's working practices (following Charles Clarke's leadership) by the then newly appointed John Reid MP. A period of reorganisation is still under way. Apart from the disruption to the unit's operation that may have been caused by these changes, staff were also coping with the relocation of the unit's offices during the research period.

Taking into account all these additional stresses on the unit and the tendency for organisations to be both inward-looking and defensive at such times of uncertainty, the research team and myself considered the recruitment process at the unit to be surprisingly successful. Evidently, a larger number of caseworkers in a broader range of positions within the unit would have been preferable. However, it was accepted that this was not possible. The sample being what it was, however, it is important to note that the absence of junior caseworkers in the MHU sample probably had a more limited impact on validity than originally feared. The work of the junior MHU officers is supervised, checked and authorised by the senior officers, so it seems reasonable to assume that their views are likely to be more representative of actual practice, even if they are perhaps less heterodox than those of their juniors. In addition, we felt that the sensitive negotiation and compromise that had ensured the unit's support for the duration of the project was a considerable achievement. In our view, the data that resulted from the five MHU participants was rich enough (and unusual enough because it is representative of the perspectives of a usually inaccessible population) to justify our decision to stay with the original study design despite the low number of participants.

Another arguable threat to both validity and generalisability was the apparent selection of participants by the MHU contact. The research team and I do not consider this to significantly undermine the validity and generalisability of participants' responses either. Staff were not briefed on interview content so could not prepare particular responses. In addition – and perhaps more importantly – my own anxieties about this matter were quelled by the variety of responses given by Home Office participants and the individual nature of their thinking and expression in giving responses. Indeed,

some of them stated explicitly that they held views that differed from those of their colleagues.

Overall, in terms of MHU involvement and the negotiations that took place with senior management in order to maintain their support of the study, I do not think that sample size or validity of responses could have been improved had the relationship been handled differently. The involvement of the Home Office in the research was considered important enough for compromises to be made in terms of study design. One of the proposed markers of quality in qualitative research is relevance (e.g., Elliott, Fischer & Rennie, 1999; Mays & Pope, 2000). The fact that this research project was able to take advantage of the unusual co-operation of the Home Office in order to add to the existing knowledge base regarding insight into offending behaviour (and forensic decision-making more generally) justified, to my mind, the compromises that were made with respect to validity and generalisability.

The original intention at the start of research process was for me to complete a forensic placement as part of my Clinical Psychology training programme during the period of data collection. I had hoped that this would provide me with a sound understanding of forensic assessment and working practices within forensic psychiatry settings which would improve the chances of securing a good sample of RMOs (through contact with these colleagues), improve my ability to develop the dialogue during research interviews, and lead to a deeper understanding of the issues pertinent to the research subject. In the event, however, this placement was not possible due a change in my personal circumstances. Although initially I was concerned that this distance between the research subject and my clinical experience

and knowledge would impede my understanding of the construct and processes under examination, on reflection I consider this to be an advantage. I was a stranger to both the MHU and the forensic sites (although admittedly aspects of the clinical sites were more familiar to me as a clinical psychology trainee) which perhaps enabled a similar approach to both groups of participants. Had I been affiliated to one of the research sites my approach to participants at the Home Office may have differed significantly to my approach to RMOS. Certainly, there would have been greater potential for personal, intellectual, and professional biases in my questioning and understanding of responses. In particular, as my external supervisor commented, I might have had specific clinical cases in mind myself when interviewing and when analysing data, as well as the contents of previous conversations with colleagues on related matters. Circumstances being as they were, I came with no preconceived ideas about the construct in question or the processes by which it might be assessed. This more equal 'distance' between myself and the two professional groups under investigation could be argued to have enhanced the credibility, and so validity, of the findings (Mays & Pope, 2000).

5. How validity and generalisability could have been improved

A further way in which the quality of qualitative research projects is enhanced is through testimonial validity or respondent validation (Elliott et al., 1999; Lincoln & Guba, 1985; Mays & Pope, 2000; Stiles, 1993). Ideally, findings resulting from the analytical process in this study would have been checked and validated by respondents. As stated in Part 2 of this thesis, this procedure was not carried out due to participants' heavy work schedules. Many of the respondents wished me to confirm

the limited nature of their required commitment to the study prior to the interview. The research team and I decided that to re-approach respondents with summaries of their interviews and expect considered responses to these might antagonise both them and their line managers. At the MHU, in particular, I expected that I would have difficulty explaining the importance of this methodological process and would risk alienating the contact person who was already reluctant to recruit further participants. The research team and I agreed that the process of analysis, which involved all parties reading the transcripts and then scrutinising my interpretations, acted as a means of general error checking that might be considered to compensate for the failure to ensure testimonial validity (Elliott et al., 1999). However, in retrospect it has occurred to me that in seeking testimonial validity data I need not have approached all participants. It should have been possible to seek testimonial validity data from at least a couple of the respondents who appeared less concerned than others with guarding their time in terms of contributing to the research. Had I been able to demonstrate these participants' satisfaction with interpretations, the ability of the analytic procedure to produce valid findings could have been extrapolated to the remaining transcripts thereby enhancing the validity of the study's findings as a whole. If further I were to undertake further research using qualitative methodology, I would seek testimonial validity data from at least some respondents.

Triangulation of methods of data collection also could have improved the findings' validity (Elliott et al., 1999; Mays & Pope, 2000; Packer & Addison, 1989). During the process of developing the interview schedule for the project the research team and I discussed and then rejected the idea of using discussion of clinical vignettes to elicit information about how insight into offending behaviour was being understood and

assessed. We had agreed that this method of data collection would be both difficult to develop without imposing preconceived ideas about the nature of the construct under investigation upon participants, and bring an artificial feel to that part of the interview whilst also producing hypothetical data. Instead it was decided that it would be better to ask participants to talk freely about real clinical cases where they had had to make a decision relating to insight into offending behaviour (see Part II of the Interview Schedule, Appendix 4). In retrospect, I think that the study design could have benefited from discussion of clinical vignettes in addition to the interview process described in Part 2 of this thesis. Analysis of participants' responses to clinical scenarios outlined in a vignette could have served a useful triangulation function, helping to validate the findings from the transcripts of the main interview. In undertaking future qualitative research, I would consider including suitable triangulation methods such as this in the study design.

6. The interview schedule

Apart from the regret that the interview schedule had not included a discussion of clinical vignettes, I think that overall the interview schedule was successful, in that it set the context for an easy discussion and elicited a large quantity of rich data about the issues under scrutiny. The schedule was developed over a lengthy process of discussion, piloting and redrafting involving all members of the research team. Due to the time constraints on this part of the research process, however, it was not possible to pilot the schedule more than once. Although the finished design was successful, some weaknesses became apparent over the period of data collection and analysis. In particular, there were certain questions that I regretted not including, which seemed,

in retrospect, to be obvious omissions. In particular, I should have asked participants explicitly about the importance they placed on insight into offending behaviour in the risk assessment process. A further area of questioning that could have produced useful findings was participants' understanding of the relationship between insight into mental illness and insight into offending behaviour. In both these areas, interesting data resulted both from some participants' musings on these issues, and from others' inferences in their responses to related questions. It would have been better if these questions had a formal place in the interviews of all participants.

A further issue with the schedule that could have been prevented with additional revision was its production of large amounts of data that did not have specific relevance to the research questions. For example, a substantial amount of data was produced from the questions in Part 1 (see Appendix 4) of the interview schedule relating to the working relationship between RMOs and the MHU. This was originally included due to the unknown nature of the decision-making process relating to risk assessment involving both parties. It was reasoned that it would be important to have this contextual information. Although this data is in itself interesting (and is certainly substantial enough to provide the basis for a further paper on risk assessment decision-making and the dialogue between these two distinct groups), for the present purposes it served mainly to delay many parts of the research process due to the extra (and ultimately wasted) time spent on transcription and analysis. However, it also seems likely that where a subject is being investigated for the first time (as was the case here), these mistakes are inevitable and perhaps I should have allowed more time due to this. Firstly, it is difficult to know what questions need to be asked when little is known about the subject area. Secondly, it is important to collect any contextual

information that may be informative even if ultimately it is shown to be superfluous.

All these oversights and the subsequent consideration of them will usefully inform future research into insight into offending behaviour and the production of more finely tuned research tools.

7. Framework analysis

An aspect of the study that I was unreservedly satisfied with was the method of qualitative analysis used. The appropriateness of the framework analysis approach for this project with its potential for application to policy and ‘actionable outcomes’ (Ritchie & Spencer, 1994, p. 173) is outlined in Part 2 of this thesis. A further important factor in the choice of methodology was the nature of the data resulting from piloting the interview. This was apparently more cognitive than experiential (in that much of it was participants’ communication of their understanding of concepts and processes rather than their experiences of these). It was therefore considered less suited to discourse analysis or interpretative phenomenological analysis (also known as IPA) than framework analysis, with its aim of ‘providing answers’ about specific areas relevant to policy-makers and practitioners about which there is a dearth of information (Ritchie & Spencer, 1994, p. 175). A further appeal of this method of analysis is its visibility, with its clear summarising and displaying of summarised and analysed data in the charting process (see Appendix 8). Not only might this transparency of the analytical process be considered to enhance the validity of the research findings, but it also clarifies the systematic nature of the qualitative research process. This might be especially important to interested parties at the MHU (many of

whom may be unfamiliar with qualitative methodology) and make it more likely that these findings be considered informative by policy-makers.

8. Limitations of this study and future research

This research project has produced some important initial findings about understandings and assessment practices relating to insight into offending behaviour. These have prompted consideration of future areas that members of the research team and I would like to explore. In particular, we accept that the present study has limited generalisability due to its relatively small samples and number of sites. The conclusions of the study might have greater credibility if a larger study was carried out but with a more refined interview schedule, the use of vignettes, and, most importantly, with more participants from a wider range of settings and professions relevant to the criminal justice system, and not only related to offenders with mental disorders. Other groups to include might be psychologists (both those working in forensic mental health settings and in prisons), psychiatric nurses, prison workers, members of the Parole Board and Mental Health Tribunals and so on. Indeed, it was an early matter of interest and speculation to the research team that insight into offending behaviour was an accepted term within the UK Parole Board processes (see Parole Board, 1997, p.18; Home Office, 2004). It was perhaps not surprising that our data revealed in psychiatrists' understanding of the construct a predominance of models based on cognitive-behavioural considerations or on insight into mental illness, and that this was also true for caseworkers, because their understanding of these issues is apparently mainly informed by their dealings with mental health professionals. However, this raises some interesting questions about how those

outside mental health services might conceptualise insight into offending behaviour. A further important area for investigation is how the information gathered here can be reconciled with the wealth of literature about insight into mental illness. Many participants apparently considered insight into offending behaviour to constitute part of insight into mental illness (as do clinicians and researchers in the wider forensic psychiatric community, as was evident from the literature review described in Part 1 of this thesis). It would be interesting to develop a deeper understanding of the construct and its relationship with insight into mental illness and perhaps propose a model of insight into mental illness, specifically applicable to forensic settings, which explicitly includes insight into offending behaviour.

9. Conclusion

Overall, I was pleased with the design and outcome of the study, and consider it to have added usefully to the knowledge base of forensic risk assessment. The experience of undertaking the research and reflection on the research process has led me to develop my own ideas about the production of good quality qualitative research. I hope to apply this knowledge in designing future research projects that would build on these preliminary findings concerning insight into offending behaviour.

References

Dent, S. (1997). The Home Office Mental Health Unit and its approach to the assessment and management of risk. *International Review of Psychiatry*, 9, 265-271.

Elliot, R., Fischer, C.T., & Rennie, D.L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, 38, 215-229.

Eastman, N. (2006). Can there be true partnership between clinicians and the Home Office? *Advances in Psychiatric Treatment*, 12, 459-461.

Home Office (2004). *Directions to the Parole Board under section 32 (6) of the Criminal Justice Act, 1991: Release and recall of life sentence prisoners*. London: HMSO

Lincoln, Y. & Guba, E.G. (1985). *Naturalistic Inquiry*. Beverly Hills, CA: Sage.

Mays, N. & Pope, C. (2000). Qualitative research in health care: assessing quality in qualitative research. *British Medical Journal*, 320, 50-52.

Mental Health Act (1983). In Department of Health (1998), *Code of Practice to Mental Health Act 1983*. London: HMSO.

Moody, E., & Snow, P. (2005). Mental Health Unit. *The British Journal of Forensic Practice*, 7 (4), 21-26.

Packer, M.J. & Addison, R.B. (1989). Evaluating an interpretive account. In M.J.Packer & R.B. Addison, *Entering the circle: Hermeneutic investigation in psychology*, pp. 275-292. Albany, NY: SUNY Press.

Parole Board (1997). Report of the Parole Board for 1996/7. London: HMSO

Ritchie, J., & Spencer, L. (1994). Qualitative data analysis for applied policy research. In A. Bryman & R.G. Burgess (Eds.), *Analyzing Qualitative Data* (pp.173-194). London: Routledge.

Srinivas, J., Denvir, S. & Humphreys, M. (2006). The Home Office Mental Health Unit. *Advances in Psychiatric Treatment*, 12. 450-458.

Stiles, W.B. (1993). Quality control in qualitative research. *Clinical psychology Review*, 13, 593-618.

Appendix 1:
Ethical approval letter from Oxfordshire
Ethics Committee A

**Oxfordshire REC A**

2nd Floor, Astral House
Chaucer Business Park
Granville Way
Bicester
OX26 4JT

Telephone: 01869 604077

Facsimile: 01869 604055

08 August 2006

Mrs Zenobia Storah
Trainee Clinical Psychologist
University College London
sub-Dept of Clinical Health Psychology
University College London
4th Floor, 1-19 Torrington Place
London
WC1E 6BT

Dear Mrs Storah,

Full title of study: A qualitative research project to explore and compare how responsible medical officers of patients on Home Office restriction orders and Home Office caseworkers make judgements about patients' attitudes to offending behaviour

REC reference number: 06/Q1604/105

Thank you for your letter of 25 July 2006, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). There is no requirement for other Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Application	5.1	13 June 2006

Investigator CV	Zenobia Amy Carnwath	
Protocol	v4	11 May 2006
Covering Letter		13 June 2006
Letter from Sponsor	UCL	11 May 2006
Peer Review	Nancy Pistrang	03 December 2004
Compensation Arrangements	AON Insurance	01 August 2005
Compensation Arrangements	UCL	19 May 2006
Interview Schedules/Topic Guides	v3	18 March 2005
Participant Information Sheet:	2	25 July 2006
Participant Consent Form	2	25 July 2006
Response to Request for Further Information		25 July 2006
Supervisor's CV	Michael Watts	

Research governance approval

You should arrange for the R&D department at all relevant NHS care organisations to be notified that the research will be taking place, and provide a copy of the REC application, the protocol and this letter.

All researchers and research collaborators who will be participating in the research must obtain final research governance approval before commencing any research procedures. Where a substantive contract is not held with the care organisation, it may be necessary for an honorary contract to be issued before approval for the research can be given.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

06/Q1604/105	Please quote this number on all correspondence
---------------------	---

With the Committee's best wishes for the success of this project,

Yours sincerely,

Email:

Enclosures: Standard approval

Copy to: Ms Oke Avwenagha
UCL Biomedicine R&D Unit
Room G652. Medical School Admin Corridor
Royal Free and University College Medical School
Rowland Hill Street
London
NW3 2PF

Appendix 2:

Ethical approval from Trust Lead for Research (Site A)

and

Chair of Research and Development Committee (Site B)

ll/hr h:rp/storah-sol

1 September 2006

Zenobia Storah
Trainee Clinical Psychologist
Sub-Dept of Clinical Health Psychology
University College London
4th Floor; 1-19 Torrington Place
LONDON
WC1E 6BT

Kent Forensic Psychiatry Service
Trevor Gibbens Unit
Hermitage Lane
Maidstone
Kent
ME16 9PH

Dear Zenobia

Thank you for the copy of the Ethics Approval for your research project. I would be grateful if you could sign the enclosed Statement of Liabilities and return it to me. Once your Honorary Contract is in place, you can proceed with your research within the Kent Forensic Psychiatry Service.

Please contact me if you have any queries.

With best wishes,

Yours sincerely

Dr Lona Lockerbie
Chair - Research Committee

Enc: Statement of Liabilities



Chairman - Peter Smallridge
Chief Executive - Erville Millar

Our Ref: RB/ds

09 February 2007

Zenobia Storah
09 Granville Road
London
E17 9BS

Dear Zenobia

Re: Honorary Contract for Researchers.

I am pleased to enclose two copies of your Honorary Contract. Could you please sign both copies, return one copy to me and retain the other for your records.

Should you have any queries with regard to this matter please do not hesitate to contact me.

Yours sincerely

Ruth Bailey
Associate Director of Human Resources

Encs.



Chairman - Peter Smallridge
Chief Executive - Erville Millar

Barnet and Chase Farm Hospitals

NHS Trust

Barnet Hospital
Wellhouse Lane
Barnet
Herts
EN5 3DJ

2 October 2006

Zenobia Storah
Trainee Clinical Psychologist
Sub-department of Clinical Health Psychology
University College London
1-19 Torrington Place
WC1E 6BT

Dear Zenobia Storah

How responsible medical officers of patients on restriction orders and Home Office caseworkers make judgements about patient's attitudes to offending behaviour

Thank you for your letter of 22nd August 2006, requesting for this Trusts approval of the above mentioned research project.

As you have confirmed that you have gained ethical approval from South East Multi-centre Research Ethics Committee, I am pleased to confirm that on behalf of Barnet & Chase Farm Hospitals Trust I approve your research project to take place within our organisation.

If you have any further questions please do not hesitate in contacting Pauline Ferns our Research contact for Barnet & Chase Farm Hospitals Trust on:

Tel: 020 8375 2213
Fax: 020 8370 9078
Email: pauline.ferns@bcf.nhs.uk

Associate Medical Director and Trust Lead for Research
Barnet & Chase Farm Hospitals Trust

Appendix 3:
Participant information sheet
and consent form



Sub-Department of Clinical Health Psychology

UNIVERSITY COLLEGE LONDON

GOWER STREET LONDON WC1E 6BT

Information sheet for potential participants

Oxfordshire Research Ethics Committee 'A' (ref: 06/Q1604/105)

Clinical decision-making about attitudes to offending behaviour

1. What is the study about?

The study aims to answer questions about how 'responsible medical officers' (RMOs) and Home Office (MHU) caseworkers understand and make judgements about patients who are on restriction orders, and their attitudes to their offending behaviour. The Home office currently requires RMOs to make such clinical judgements about these patients when applying for transfer, leave or discharge. The researchers are interested in how RMOs make these clinical judgements, and how Home Office caseworkers understand their reports in this two-stage process of assessment. We are interested in the processes by which decisions about patients are made, and whether there are individual differences and/or differences between the two professional groups.

2. How are we intending to research this?

The principal researcher hopes to interview ten RMOs, recruited from over two sites (North London Forensic Services and Kent Forensic Psychiatry Services), and ten Home Office (MHU) caseworkers. The interviews will last about an hour, and will be semi-structured and open-ended. It is hoped that recruits will be able to express their views freely about the subjects raised.

3. Why have I been chosen?

We are approaching all the RMOs at the two medical sites and a sample of MHU caseworkers and providing them with information about the study. We hope that some of these professionals will be interested in taking part.

4. Do I have to take part?

No. It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. This will not affect any aspect of your employment

5. What will happen to me if I take part?

If you decide to take part, you can contact one of the researchers (see contact details below). The principal researcher will contact you to arrange a time to meet that would suit you. Interviews will take place at your place of work in a private room and will last about an hour. Before the interview, you will be asked to sign a consent form saying that you have read this information sheet and agree to be interviewed. We would like to record the interviews to give us a detailed picture of what participants think and feel about the processes by which decisions about patients' attitudes to offending are made. When we publish our findings, it may be useful if we can quote part of your interview (with all names and any other identifying material removed). We will not do this without your consent, so you will also be asked whether you consent to the recording of your interview and the quotation of extracts from your interview on the consent form.

Anything you say in interview will be kept confidential. Nothing you say will be shared with any of your colleagues. All data will be anonymised and stored in a locked cabinet. All recordings and transcripts will be destroyed after analysis. You will also be asked whether you consent to this storage and processing of your personal information.

You may withdraw your consent to any of these three points at any time in the future, without having to give a reason.

No other involvement in the study will be asked of you after this initial interview.

6. Are there any circumstances in which what I say in interview will not be kept confidential?

Yes. In the unlikely event that the information that a participant provides suggests malpractice, the researcher is obliged to report her concerns to her line manager at the Trust. The line manager will then implement the usual procedures for cases of suspected malpractice as outlined in the respective Trust's policy. In cases of suspected unprofessional practice at the Home Office, the researcher will be obliged to raise her concerns with the Head of Caseworking.

7. What do I have to do?

You will be asked about various aspects of the assessment of restricted patients when applications are being made for leave, transfer, or discharge. We will be interested in your views about the clinical and political processes involved, and about your own professional practice and experiences of being involved in these processes.

8. What are the possible disadvantages of taking part?

There are no foreseen disadvantages of taking part in the study.

9. What are the possible benefits of the study?

You will be contributing towards research that will help clinicians and academics understand more about the processes by which decisions about restricted patients' attitudes to offending are made.

10. What will happen to the results of the study?

The study is being conducted as part of an educational project. Data collected in the study will be used to form the basis of a doctoral thesis and papers in peer-reviewed journals. All data published will be anonymised.

11. Who is organising and funding this research?

The research is being organised by the researcher, Zenobia Storah (Trainee Clinical Psychologist at University College London), under the supervision of Dr Anne Sheeran (Clinical Psychologist at Kent Forensic Psychiatry Service) and Dr Mike Watts (Clinical Psychologist at North London Forensic Services). It is being undertaken within the sub-Department of Clinical Health Psychology, University College London. It is sponsored by University College London.

12. Who has reviewed the study?

The study has been internally reviewed within the sub-Department of Clinical Health Psychology at University College London. It will also be subject the review by local ethics committees at both medical sites.

13. How do I obtain further information or to agree to take part?

For further information about the study, or to agree to take part please contact the principal researcher, **Zenobia Storah**

Address: The sub-Department of Clinical Health Psychology, 1-19 Torrington Place, London, WC1E 6BT



Sub-Department of Clinical Health Psychology

UNIVERSITY COLLEGE LONDON

GOWER STREET LONDON WC1E 6BT

Clinical decision-making about attitudes to offending behaviour

Consent Form for participants

Oxfordshire Research Ethics Committee 'A' (ref:06/Q1604/105)

Please read the following statements and circle your answer:

1. I have read the information sheet for the above study and have had an opportunity to ask any questions I may have about the study and participation in it.

Yes

No

2. I agree to be interviewed for the above study. I understand that my participation in this study is voluntary, and that I may withdraw my consent at any time, without giving reason, and without my employment being affected.

Yes

No

3. I agree to having the discussion recorded. I understand that I am consenting to this voluntarily and that I may withdraw my consent to this at any time, without giving any reason, and without my employment being affected.

Yes

No

4. I agree to anonymised extracts of my interview being cited in an academic thesis and in published papers in academic journals. I understand that I am consenting to this voluntarily and that I may withdraw my consent to this at any time, without giving any reason, and without my employment being affected.

Yes

No

5. I agree to the storage and processing of the information that I provide in the interview and about myself before the interview. I understand that I am consenting to this voluntarily and that I may withdraw my consent to this at any time, without giving any reason, and without my employment being affected.

Yes

No

If you have any questions about anything on this form please ask the researcher.

Participant's name (Please print)

Signature

Date

Researcher's name (please print)

Signature

Date

Appendix 4:
Interview schedule

Clinical decision-making about attitudes to offending behaviour

Interview schedule

In this interview, we are interested in your views and experiences of the Home Office processes in place for decision-making about patients on section 37/41. We would like to know more about how professionals reach decisions about these patients, and how they understand terminology used by the Home Office. We would like to emphasise that we are not testing your knowledge of the system and that there is no single correct answer to these questions. During the interview, we at times refer to documentation from the Home Office intended to guide RMOs when they are writing reports for the Home Office when making applications for leave, discharge or transfer. Are you familiar with these guidelines? Would you like to see them?

Have you seen the information sheet? (present to participant). Offer opportunity to ask questions about the study. If agreeable, sign consent forms and continue.

Part 1

Introduction:

To all participants: in the following questions, I want us to talk about the information that RMOs provide for the Home Office both in annual reports and when applying for leave, transfer or discharge for their patients on restriction orders. Is that clear?

1. What do you think is the purpose of the information required from RMOs by the Home Office?

If necessary ask the following questions by way of prompting:

2. What do you think the Home Office wants to know from RMOs about their patients in these reports?
3. Why do you think it is important for the Home Office to know these things?

Understanding of terms:

1. In its guidelines to RMOs, the Home Office talks about 'offending behaviour'. What do you understand by this phrase?
2. This same Home Office documentation also asks doctors to comment on 'other dangerous behaviour' beside the index offence. What do you think it means by this?
3. The documentation also asks for comment on the patient's 'attitudes to [their] offending behaviour'. What do you think the Home Office means by this phrase?

Prompt: what sort of information does it want from doctors in order to make a decision about this?

4. The Home Office documentation refers 'insight' in the context of offending behaviour. What does the term 'insight' mean to you in this context? How do you think you would know that the patient had insight? *What sort of information would the Home office be looking for to make a decision about whether a patient had insight or not? [In the case of RMOs, ask for information about clinical assessment – psychometric? What markers are looked for?]*
5. The Home Office asks whether a patient's insight is 'real' or 'learned –for example in therapy'. How would you know if a patient's insight was real or 'learned'?
6. The Home Office guidelines ask RMOs whether the patient now 'learns from experience and takes into account the consequences of their actions'. How do you think you would know that the patient was doing this? *What sort of information would the Home office be looking for to make a decision about this?*
7. Do you think the phrases 'a patient's attitude towards offending behaviour' and 'a patient's insight into their offending behaviour' are interchangeable?

Evaluating process:

8. What do you consider to be the most important considerations when you are providing/evaluating (delete where appropriate) information about patients for the Home Office?
9. Go through each factor given and ask: 'Why do you think that x is important?'
10. When evaluating a patient for the Home Office, what else, apart from a patient's presentation, influences your judgement? *E.g, whose opinions do you consider (e.g. patient, family, probation officers, other MDT members, victim/ victim's family?), are there other sources of information you take into account? (e.g. past experience, journal articles, training, media)*

Mental illness –clarification of terms

To all participants: We are asking the following questions to clarify terms that are used both in the context of offending behaviour and of mental illness – we want to know if you understand these terms differently depending on context.

11. In the context of mental illness, what does the term 'insight' mean to you? *E.g. 'does the patient have insight into their illness'?*

12. In cases of mental illness, the Home Office guidelines also ask the RMO to make a judgement about the extent to which the patient has insight into their illness. What would indicate to you that a patient had insight into their mental illness? *What would indicate to you that they did not have insight into their illness?*

Other

13. Do you link a patient's attitude to their offending behaviour to the risk that they may re-offend? *If so, how?*

4. Finally, what are your views of the Home Office requirements for leave, transfer or discharge applications and annual reports?

Part 2

This part of the interview aims to explore the individual process of decision-making about insight for each RMO, and to look at the RMOs' experiences of this process. This section would be less structured, with the RMO responding to the instruction, with clarifying questions and prompting from the interviewer where necessary.

1. Tell me about a time **in the last six months** when you found it relatively easy to evaluate a patient in terms of their insight into their offending behaviour.
Prompts:- patient's background – index offence etc, what was it that indicated to you that this patient did/did not have insight? how did you go about assessing the patient? How confident did you feel about your decision?
2. Tell me about a time **in the last six months** when you found it difficult to evaluate a patient in terms of their insight into their offending behaviour?
Prompts:- patient's background – index offence etc, what was it about this patient that made it so difficult for you to reach a decision? How did you go about assessing the patient? How did you reach a decision in the end? How confident did you feel about this final decision?

Appendix 5:

Samples from interview transcripts

Sample from HOCW5's interview

ZS: I'm just waiting for the machine to kick into action..Ok. Before we go through the questions that I've got, can you just give me an outline of what you do in the unit.

P5: What I do? Well, most what I do, frankly, is the Home Office end of the Mental Health Bill. I'm pretty much full-time on looking after part 3 of the Mental Health Bill, which is the new provision for offenders .. but as you know I am normally called Head of Caseworking because I was a casework manager for more years than I care to admit. Um.. I suppose I have a sort of quasi-consultant function.

ZS: And how much of.. that takes up what.. some of your time during the week?

P5: Yes. Ok to clarify, specifically here we are talking about patients of section 37/41 and we want to know more about how professionals reach decisions about them. And how particular terminology that's used by the Home Office is understood. Um.. and we're interested in your opinions about the guidelines as well.

ZS: OK to start off.. and what we're thinking about here is the information that is provided for the RMOs when they are writing applications for leave, transfer or discharge.. this stuff? You may have seen it a long time ago..

P5: Yes

ZS: What do you think the HO wants to know from RMOs in these reports?

P5: As a generality, we want to know the current state the care team's thinking on how the offending is related to mental disorder; the extent to which re-offending can be affected by treating the disorder. The effect of treatment to date, and the prognosis of that, if you like, in terms of how outstanding risk can best be managed.

ZS: Right. You talk about outstanding risk, are you talking about the possibility of re-offence?

P5: Yes. Although one should probably clarify in this context, we are talking about the sort of offending that threatens serious harm to others. We're not in the business of preventing people ..breaking drugs legislation and so forth. It's quite an important distinction. We certainly should not be using our powers as a regulatory function in crime prevention.. we're there to prevent serious harm.

ZS: So the Home Office wants to know those things to help them prevent serious harm to the public..

P5: Yes.

ZS: And is that also.. does the risk to the individual patient come into this as well or not?

P5: I think we tend to regard it as inherent. I often see debates about the respective risks of harm to others and harm to self, but my understanding is that most clinicians don't actually draw a clear distinction because it's rare when you can predict that the risk of harm is exclusively to self or exclusively to others or where it sits on a continuum.

ZS: OK.

P5: So yes. Harm to the patient is a relevant part of it. Although formally I guess what we are looking at is risk to the public.

ZS: Right. In the guidelines that I showed you the Home Office talks about 'offending behaviour' and also 'other dangerous behaviour'. What do you think is meant by those phrases?

P5: That's a very good question. What it should mean is .. I think.. what I've just described. The risk of serious harm occurring - physical or psychological harm which

should include 'to others or to the patient's themselves'. Um.. I don't think I want to particularly defend the distinction between those two forms of words. Because as I said earlier it's not actually part of our role to be a crime prevention regulator.

ZS: 'Other dangerous behaviour' .. say when you did do your casework a while ago, when you would read .. when that phrase is being referred to , what are you looking for specifically?

P5: I frankly never made that distinction. In fact you are reminding me now that the distinction exists. But the issue we should be looking for is the prevention of serious harm. And actually it strikes me that it's rather pedantic to draw a distinction between offending behaviour and behaviour that might lead to serious harm because it's very rare that there is any difference.

ZS: Ok. The documentation also asks for comments on the patients' – and this is a quotation - 'attitudes to offending behaviour'. What do you think the Home Office means by this phrase?

P5: Crudely, it means whether the patient is actually going to deliver compliance to the extent which enables the risk to be managed.

ZS: Ok.

P5: It's fairly apparent that if the clinician tells you that somebody is dependent on them for their anti-psychotic medication then it is a matter of record that the person will drop their medication at the first opportunity. And that affects your risk assessment.

ZS: Ok. So that's the sort of information you'd be looking at from doctors to make a decision about a patient's attitude?

P5: What we're interested in of course is the reality on the ground which is sometimes more difficult to pick out. But at it's simplest, when you get someone who's offence seems to have risen exclusively from a psychotic episode such that it was completely out of character to the person when well, when they are recovered they are completely horrified, they feel remorse about what they have done then it clearly makes the risk more easy to identify and manage. And remorse is part of insight is part of a continuum of how the patient is going to respond to treatment and how effective it's going to be in preventing harm. But I wouldn't want to give the impression that we think we have any great powers to interpret what clinicians tell us in terms of remorse, insight or anything else. We look to the clinicians for guidance on that.

ZS: Ok.

P5: Some cases seem to be very simple like the one I've just described, where somebody acts out of character because of a psychotic episode which is controlled by medication. At the other end of the continuum you've got the sort of personality disorder type whose normal behaviour pattern is to harm others and enjoy it. And they'll probably express remorse but they aren't really going to deliver it.

ZS: And what you suggest when I ask .. when I asked how you understood attitudes to offending behaviour .. and what that means is that.. is.. you seem to be talking about both insight into the mental illness and insight into the offence .. in that .. both of those two are important.

P5: Yes.. in theory the way the system works is to assess the way in which the mental disorder and the offending behaviour are - at least potentially - bound up. Um .. this means that in most cases you can't actually separate these things very effectively.

ZS: I guess some of these questions might appear quite pedantic, but we're quite interested in how the terminology is understood .. seeing as it's being.. well, the way

in which it's being used. The Home Office documentation refers to insight in the context of offending behaviour. How do you understand insight in the context of offending behaviour? And how do you think you would know that a patient had insight in the context of offending behaviour?

P5: We would ask the clinician.

ZS: And would you take what the clinician said as... would it be an entirely clinical decision, I suppose is what I'm asking.

P5: If I can step slightly back from that. We must never take what amounts to a clinical or medical decision - we are not qualified to do so. What we are doing is what should be a fairly common-sense audit of the coherence of the evidence we're getting. Now if the record of patient's management makes it clear that the RMO who is reporting to us seems to understand the conditions, seems to understand .. that the diagnosis has a clear and defensible risk strategy attached to it then yeah.. if the clinician says they've got insight then that's part of the equation. If on the other hand you've got someone whose had fairly chaotic management or from a number of different teams so you've got a lot of conflicting evidence then by definition you take what you see with a greater degree of scepticism, And if you are really concerned you may go for a second opinion of your own..

ZS: So..

P5: That would be the gist of my answer to anything about how we interpret what clinicians tell us. We cannot ever query something which is a clinical decision except if we are sufficiently worried about the lack of coherence of the evidence that we've got. And the potential outcome of that lack of coherence, we may well go for a second clinical opinion. We as caseworkers are not going to say you say he's got insight but

we don't believe it. We might say 'Well, the evidence leading to this is patchy and incoherent so let's get another opinion'.

Sample from RMO3's interview

ZS: Ok. Um.. when I'm talking about 'documentation' in this interview, I'm referring to the documentation that the Home Office sends out to RMOs – the guidelines for applications for leave, transfer and discharge.

P8: Yes.

ZS: So you know what I'm talking about? Ok.. Um.. first of all do you specialise in working with any particular client group within forensic services?

P8: No. So typically you'd see psychosis in the inpatients, but you also see psychopathy .. and I've got a man with Asperger's Syndrome at the moment. But it's mainly psychosis with co-morbid ASPD and co-morbid substance misuse problems, including drink.

ZS: And do you have any involvement with the LD service here?

P8: No. None at all.

ZS: Ok. First of all can I ask you what you think the Home Office wants to know about RMOs about their patients in the reports?

P8: This is annual updates? Or specifically looking at the discharge process?

ZS: Um.. well, I suppose first of all if you think about the discharge process, then if there are any differences with the annual reports you can tell me about those.

P8: Well, I suppose at a baseline, having major principle diagnoses, they want to know to what extent you have addressed the illnesses involved. Which are plausibly related to the offending behaviour and the risks in general. So, for example, if your main diagnosis is schizophrenia, they'll want to be assured that the symptomatology

has remitted. They want to know about the patient's insight into their illness – to what extent do they believe they have a mental illness and are they prepared to take medication for that. They want to know about compliance with medication. So is that assured through depot form rather than oral? If it is oral, a reasonable proportion of our patients will be on clozapine, so again they'll want to know about evidence of compliance with that. So that's the kind of questions you've got to answer about your baseline schizophrenia. Then if there is also co-morbid anti-social behaviour, they are also interested in the extent to which any such attitudes have changed, how they've changed in terms of whether there has been any specific therapy looking at those anti-social attitudes. Likewise, if there is a co-morbid substance-misuse problem, what work has been done to address that. Uh.. again, what evidence is there that their drug misuse has subsided. I.e. do you have urine analyses that say he hasn't touched anything for more than two years? He's been in a substance misuse group and his attitudes towards the substances and has it fundamentally changed etc. Um.. so that's the typical medium secure patient, and those are the typical areas you'd have to address. And then we'd also look at.. in a structured assessment way, what's changed. We'd use the HCR-20 to say .. which, you know, covers things like insight, exposure to de-stabilisers, stress etc etc. So we'd try to work that into any document which is asking for, for example, deferred discharge...

ZS: So you'd give the results from your HCR-20 in correspondence to the Home Office?

P8: Yes. I'd say 'This is what my baseline was, this is what has changed'. I don't typically use numbers, but I'd say these are areas which an instrument like the HCR-20 would highlight as important. And these are the ways that we've addressed them in their time in medium security.

ZS: Ok. So are there any differences when you're writing the annual reports, in terms of contents, or is it the same sort of areas?

P8: It's the same sort of areas. You're saying 'These were the problems at the beginning of treatment; these are the ways in which we are trying to address them; this is the progress we've made; these are the areas of difficulty; this is what remains to be addressed ...'

ZS: Ok. Out of interest – you were talking about the HCR-20. When you refer to that when writing to the Home Office, do you sure that they know what you are talking about when making reference to a particular psychometric.

P8: Yes. I guess I do assume that they know. I'm not using jargon, but I'm saying 'The structured risk assessment, the HCR-20' and then list the historical items which are of importance, then the clinical items which are of importance. You know, I do spell it out. I don't sort of say 'Well, the H score was 20..' And even if they had no specialised knowledge other than 'It's some tool that Dr [P8] has used', they'd still be clear about what it assesses. But I guess they don't know the history behind it, or they may not know that.

ZS: I'm going to ask you a bit more about your relationship with particular caseworkers later on, if it's relevant, but I was wondering, because you've mentioned psychometrics, do they every particularly ask for that? Do you .. do they ask for specific evidence, such as that?

P8: For structured clinical judgement?

ZS: Yes.

P8: No.

ZS: So it's something you put in because..

P8: Because I do for tribunals, and there's no reason not to share that information with the Home Office.

ZS: Ok. And can you tell me why you think it's important for the Home Office to know the things you are talking about? (Pause)... What do you think they are getting at?

P8: Well, I would imagine.. my fantasy (laughs) would be that they are interested in the progress of the patient, and that what they want to see is that the risk factors are being addressed or that they are not static and will never change, but that certain things are dynamic, and that's what we are trying to do during the period of medium security. And having faith in us when we say something's changed, that it has changed. Um.. and that therefore you would hope they would support whatever it is you are asking for, be that more periods of leave, or unconditional discharge. In my experience, the baseline is 'No. He needs to be .. or she.. needs to continue to be detained'.

ZS: Right. And you said before we started recording that that has happened almost every time you've made an application?

P8: Yes. In my two years I've probably had six tribunals, and in each of them, despite the fact that I've been able to demonstrate what they've asked of us, they've said no. But the tribunals have agreed with us.

ZS: So you find it much easier to get through the tribunals than the Home Office.

P8: Well, in terms of the deferred conditional discharge decision, as I say, the Home Office has always said 'No, he needs a further period of therapeutic work', but the tribunals have agreed with us to date.

ZS: Do you think it's sensible what the Home Office comes back to you about? So in those situations, where it's disputing your judgement... or do you not see it as disputing your judgement?

P8: Yes, it is essentially. It's saying 'Dr [RMO3] ... we don't agree with Dr [RMO3]'. It's difficult to .. the frustrating thing is that it's not an evidence-based decision. It seems to be.. well, it would be intriguing to me to know exactly how they come to these decisions. Because if you can demonstrate that the various things have changed, what are they making that decision on? Why are they not agreeing with you? As it happens, now going into a tribunal, I know the Home Office will say 'No', but I know that it's not going to affect the tribunal's decision, so I'm not going to be too bothered about it. But I would be intrigued to know what proportion of cases they agree with the RMO. You know.

Appendix 6: Analysis –Frameworks

Index /Framework – Home Office data

1. HO role in assessment procedure

- 1.1. *HO role is risk assessment with key objective of protecting public safety
‘preventing serious harm’ – psychological or physical*
- 1.2. *HO objectives 2 fold – 2 key objectives: risk assessment and rehabilitation of patient*
- 1.3 *Factors of risk assessment-What HO is looking for*
- 1.4 *HO risk assessment includes risk to patient*
- 1.5. *Mental Health Unit NOT concerned with crime prevention –*
- 1.6 *Standardization of procedure*
- 1.7. *Value of HO role in assessment (participant’s view)*
- 1.8 *HO as protector of patient welfare*
- 1.9. *HO caseworkers as clinical decision-makers*
- 1.10. *HO relationship with public via the media*
- 1.11. *HO caseworking is specialist work*
- 1.12. *Nature of ‘paper relationship’ with patients on caseload*
- 1.13. *HO caseworkers’ personal and emotional response to the work*
- 1.14. *HO caseworkers pressurised in their work*

2. Characterisation of patient

- 2.1 *Patient as unpredictable, deviant, manipulative, needing control, needing to be ‘caught out’*
- 2.2 *Patient ‘not to be trusted’*
- 2.3. *‘Perfect patient’ – patient that complies, does not ‘cause trouble’*
- 2.4. *Patient as needy – in need of care/nurture*
- 2.5 *Patient as ‘difficult’/inconvenient*
- 2.6. *Distinction between 2 kinds of patients (those that offend because they are ill, and those that offend and happen to be ill)*
- 2.7. *Psychopathic and PD patients as ‘very bright’ and therefore more capable of deception*
- 2.8. *PD patients as sadistic*
- 2.9. *PD patients incapable of remorse*

3. Characterisation of RMO

- 3.1 *RMO as expert : RMO leads HO caseworker*
- 3.2 *Doctor as fallible*
- 3.3. *Doctor as pragmatic*
- 3.4. *Doctors as resistant to HO involvement/disputing value of HO*
- 3.5. *RMO as colleague – collaborative with HO*
- 3.6. *RMO as ‘other’. HO working with a medical system, but not part of it*
- 3.7. *Distinction between forensic psychiatrists and general psychiatrists*
- 3.8. *Doctors as frustrated by HO and its work/associated bureaucracy*
- 3.9 *Doctor as appreciative of HO’s specialist knowledge*
- 3.10 *Doctors’ perception of the HO as remote*

4. Insight into mental illness - definitions

- 4.1. *Compliance with medication and treatment*
- 4.2. *Understanding nature of mental illness and its effect on them*
- 4.3. *Insight into the offence = (a part of) insight into mental illness*
- 4.4. *Insight into mental illness distinct from insight into the offending*
- 4.5. *Insight into offending NOT possible without insight into the illness*
- 4.6. *Insight into mental illness is possible without insight into the offence*
- 4.7. *Patient having understanding of how to prevent*

5. Importance of insight into mental illness

- 5.1 *Insight into MI not necessarily important for progression through the forensic system*
- 5.2 *Insight not always possible (therefore other factors become more important in the rehabilitation of a patient)*
- 5.3 *Importance varies depending on diagnosis*
- 5.4 *Insight into MI necessary for progression through the forensic care system*
- 5.5 *Insight into MI linked with risk to re-offending (increased insight into illness = decreased risk of re-offending)*

6. Insight into offending behaviour – definitions

- 6.1 *Minimisation of offending behaviour*
understand impact of offence on their lives
- 6.1 *Taking responsibility for the offence*
- 6.2 *'Acceptance' of the offence*
- 6.3 *Insight into the way mental illness led to the offence (insight into the offence is part of insight into mental illness)*
- 6.4 *Remorse (and remorse reduces risk of re-offending) /regret*
- 6.5 *Understanding of how the offending behaviour has affected the patient themselves*
- 6.6 *A clear, cognitive-behavioural understanding of the offending*
- 6.7 *Insight demonstrated through 'responsible' behaviour (e.g. compliance with medication if mentally ill)*
- 6.8 *Engagement in treatment (medications/therapy)*

7 'Attitudes to offending' – definitions distinct from 'insight into offending'

- 7.1 *'Attitudes to offending' denote emotional responses (e.g. remorse, empathy, sympathy)*
- 7.2 *Attitudes refers to level of compliance with care team*
- 7.3 *Attitudes revealed by behaviour that indicates increased responsibility for actions*

8. Importance of insight into offending behaviour

- 8.1 *Insight into offending is important because related to risk of re-offending: (increased insight = decreased risk)*
- 8.2 *Insight into offending necessary for progress through forensic care system*

- 8.3 *Insight into offending not necessary for progress through the forensic system –*
- 8.4 *Insight into offending not necessarily personally helpful for patient*

9. Evaluation of insight into offending

- 9.1 *More/less difficult depending on diagnosis*
- 9.2 *Dependence of HO on doctor and clinical team to make an assessment of insight into offending*
- 9.3 *Level of difficulty of decision-making with regards to insight into offending indicates level of risk (harder the decision greater the risk of re-offence)*

Index /Framework – RMO data

1.HO role in assessment procedure

- 1.1 *Perceived HO concerns in assessment procedure*
- 1.2 *Factors of risk assessment information/ RMO's considerations in assessing for the HO*
- 1.3 *HO risk assessment: includes risk to patient?*

2. RMO role

- 2.1 *Psychiatrists' role is to treat mental disorder primarily –concern with risk is secondary*
- 2.2 *Psychiatrists' role – equal components – risk and therapeutic care of patient –*

3. Insight into mental illness – factors included in definition/factors looked for in clinical interview

4. Problems in the assessment of insight into MI

5. Relationship between insight into the offence and insight into the mental illness

- 5.1. *Insight into the offence =(a part of) insight into mental illness – ‘where MI directly led to offence, you can’t separate them very effectively’.*
- 5.2. *Insight into mental illness distinct from insight into the offending (you can have one without the other)*
- 5.3. *Insight into MI and offending distinct but related - not having insight into illness jeopardises the chances of having insight into the offence*
- 5.4. *Accepted understanding of insight into mental illness used explicitly as model for defining insight into offending behaviour*

6. Importance of insight into mental illness

- 6.1 *Insight into MI not necessarily important for progression through the system*
- 6.2 *Insight not always possible – therefore other factors become more important in the rehabilitation of a patient (compliance, external controls)*
- 6.3 *Insight into MI necessary for progression through the forensic care system*
- 6.4 *Insight into MI linked with risk to re-offending (increased insight into illness = decreased risk of re-offending)*
- 6.5 *True insight into MI is rare – not many patients achieve this – so other factors can be of more importance (e.g. control of mental illness) - RMO1*
- 6.6 *Not so important for patients who arrive in RSUs from prison (ie/ were not ill at time of the offence) –RMO6*

7. Insight into offending behaviour – definitions/factors looked for in assessment

8. Patient groups for whom insight into offending is more difficult

- 8.1 *More difficult with PD patients*
- 8.2 *More difficult for patients with (drink/drug-induced) amnesia at time of the offence*
- 8.3 *More difficult for patients with Aspergers' Syndrome*
- 8.4 *More difficult for patients who cannot emotionally accept their offence*
- 8.5 *Il of us have difficulty gaining insight into our behaviour*
- 8.6 *More difficult for patients with no insight into the illness*
- 8.7 *More difficult for patients with LD*
- 8.8 *More difficult in patients with organic conditions affecting memory*
- 8.9 *More difficult for patients with schizophrenic illnesses*

9. 'Attitudes to offending' – definitions in relation to 'insight into offending'

- 9.1 *Terms used interchangeably – both refer to same construct*
- 9.2 *'Attitudes to offending' denote emotional responses to the offence (e.g. remorse, empathy, sympathy, regret)*
- 9.3 *Denotes overall 'thinking' style around offence – positive/negative feelings about it/pro or anti-social attitudes held*

10. Importance of insight into offending behaviour

- 10.1 *Insight into offending is an 'ideal' but not always possible and therefore not the essential*
- 10.2 *Insight into offending is related to risk of re-offending: 'clear, logical relationship' (increased insight = avoidance of risk factors = decreased risk) and is therefore very important*
- 10.3 *Insight into offending not straight-forwardly linked to risk of re-offence and is therefore not the most important factor in risk assessment*
- 10.4 *Insight into offence can be a factor in risk assessment, but not the most important factor*
- 10.5 *Insight into offending is necessary for progress through forensic care system and rehabilitation back into the community*

- 10.6. Insight into offending is not necessary for rehabilitation because it is not always possible*
- 10.7 Control of mental illness more important than insight into offending*
- 10.8 Compliance with treatment can be more important than insight into offending where it is not possible*
- 10.9 External controls and support mechanisms can be more important than insight into offending*
- 10.10 Insight into offending more important in assessment of outpatients than inpatients*
- 10.11 Insight into offending is a less important factor in risk assessment of psychopaths*

Appendix 7: Analysis - Samples from frameworks with data

Sample of thematic framework with Home Office data (theme 1: sub-themes 1.1-1.9)

1. HO role in assessment procedure

1.1 *HO role is risk assessment with key objective of protecting public safety*
'preventing serious harm' – psychological or physical- HOCW 1,2,3,4, 5, 6

1.2. *HO objectives 2 fold – 2 key objectives: risk assessment and rehabilitation of patient*
HOCW4

1.3 *Factors of risk assessment/What HO is looking for*

- a. Coherency in information provided – HOCW5
- b. Nature of index offence – HOCW5
- c. Violent behaviour - HOCW1
- d. Patterns of aggressive behaviour - HOCW2
- e. What is implied by behaviour – not just obviously dangerous behaviour HOCW1
- f. Insight into offending behaviour – because patient's insight into offending is related
- g. to risk of re-offending (increased insight = decreased risk). HOCW1,2
- h. Insight into illness – HOCW2
- i. Abscond history and risk HOCW1
- j. Patient's ability to empathise with victim - HOCW1,2,4,5
- k. Mental 'stability' HOCW1,2
- l. Compliance with the care team HOCW1
- m. Understanding what 'drives the patient' – HOCW2,3
- n. Circumstances surrounding the offence – HOCW4
- o. Relationship with psychiatric services prior to the offence – HOCW4
- p. What has changed since the offence? – HOCW4
- q. Team's view of relationship between the offence and the disorder – HOCW5
- r. Extent to which re-offending risk can be reduced by treatment of disorder – HOCW5
- s. Effect of the treatment to date – HOCW5
- t. Existence and management of outstanding risk – HOCW5
- u. Whereabouts and views of victims – HOCW3, 4, 5
- v. Input of other healthcare professionals involved in case (apart from RMO) – HOCW2,4,5

1.4 *HO risk assessment includes risk to patient*

- a. EQUALLY about reduction of risk to patient and public -HOCW4
- b. More about risk to public (but risk to patient relevant) – HOCW5
- c. Not about risk to patient at all – HOCW6

1.5. *Mental Health Unit NOT concerned with crime prevention* – HOCW1,2, 3, 5

1.6 *Standardization of procedure*

- a. Procedure is standardized HOCW2, HOCW4

- b. Procedure is individualised /non-standardized because of individual patients' needs HOCW3
- c. Procedure is individualised /non-standardized because of individual caseworking styles, experience and views HOCW 1,2,
- d. Procedure is standard 'but with a fairly narrow scope for difference' – HOCW6

1.7. *Value of HO role in assessment (participant's view)*

- a. HO role as demonstrably valuable to public due to low rates of re-offending among restricted patients – HOCW5, 6
- b. HO role as valuable in terms of patient's welfare – allows mentally disordered offenders to avoid prison and receive psychiatric care – HOCW5
- c. HO role as valuable – brings into assessment procedure important elements that would otherwise be ignored - HOCW2,3,5, 6
- d. HO as valuable – offers 'unique' overview and continuity in patient care – HOCW5
- e. HO valuable – offers 'collective and historical' expertise individual doctors don't have –HOCW5
- f. HO role as valuable – in community cases in particular, as opposed to inpatient cases - HOCW1
- g. HO role as valuable – where quality of medical team is questionable – HOCW1,5
- h. HO valuable – only as 'check and balance' to doctors' evaluations - HOCW1, 2
- i. HO role as valuable because cost-effective – to tax payer and prison service in keeping mentally disordered offenders out of prison and reducing rates of re-offending. HOCW5
- j. HO role as redundant –add nothing to doctors' work – HOCW1
- k. HO role as 'necessary' for public safety HOCW2
- l. HO role as accepted status quo – not to be questioned too much 'It's what parliament wants'. HOCW2, 6

1.8 *HO as protector of patient welfare-* HOCW 2,3,4,5

- a. HO's (MHU) existence allows mentally disordered patients to be cared for – HOCW5
- b. HO protects patient from risk to self – HOCW5,2
- c. HO need to 'understand' the person that is the patient – HOCW2, 3
- d. HO need to have 'fair' expectations of the patient – HOCW2
- e. HO has no role as protector of patient welfare – HOCW6

1.9. *HO caseworkers as clinical decision-makers*

- a. HO has no role here HOCW1, 4,5
- b. HO can make valid clinical judgements HOCW2, 3, 6
- c. HO caseworkers 'need to be able to make judgements' about clinical matters – HOCW6
- d. HO not clinical decision-makers but can question clinical decisions – 'auditors' of clinical decision-making, a 'check and balance' of clinical decision-making process, HOCW2, 5

Sample of thematic framework with RMO data (themes 1-5)

1.HO role in assessment procedure

1.1 Perceived HO concerns in assessment procedure

- a. HO objective is solely risk assessment with key objective of protecting public safety preventing serious harm – psychological or physical – RMO8, 9, 6,5,4,1
- b. HO has 2 objectives– 2 key objectives: risk assessment and rehabilitation of patient – RMO7,3
- c. HO has 2 objectives varying in importance – risk assessment primary, and patient welfare a secondary concern – RMO10,7
- d. HO has 2 objectives varying in importance – therapeutic progress of patient primary, risk assessment secondary – RMO11
- e. HO is concerned about protecting public safety but also with ‘saving face’ and preventing ‘scandals’ – RMO8

1.2 Factors of risk assessment information/ RMO’s considerations in assessing for the HO

- a. *accounts of any risky behaviour (violent, aggressive or sexually inappropriate on ward/during leave) related to the index offence* RMO10, 8, 11,9,7,6,5,4,2,1
- b. *accounts of risky behaviour other than that related to the index offence* – RMO11, 8,9,6,5
- c. *ability to empathise/understand the impact behaviour had on others* RMO10, 11,9,6,5,1
- d. *Compliance with treatment* RMO9,7,5,4,3,10,1
- e. *Insight into offending* RMO10, 11,9,5,3,2,3
- f. *Patient’s response to stress in less restricted circumstances (e.g. ground leave)* – RMO8,2
- g. *Degree to which mental illness/disorder is controlled/stability* – RMO8,11, 6, 5,4,3,2,1
- h. *Alcohol and drug misuse* – RMO11,9,5,4,3,1
- i. *Absconding risk* – RMO11,5,4
- j. *Ability to understand the offending behaviour as morally wrong* – RMO11
- k. *Wish not to re-offend in the future* = RMO11
- l. *Acceptance of personal responsibility for the offence* – RMO11, 9,5
- m. *Remorse* – RMO11,6
- n. *Status of therapeutic progress*– RMO9, RMO7, 6, 5,4,3,2,1
- o. *Observed ‘irresponsible’ behaviour* – RMO9
- p. *Level of impulsivity* – RMO9
- q. *Location of proposed leave in relation to victims’ areas of residence/place the offence took place* – RMO9, 4
- r. *Ongoing risk to specific people – e.g. previous victims* – RMO7, 6
- s. *Evidence of bullying or exploitation of others on ward/during leave* – RMO7
- t. *Views of other professionals’ involved in patients’ care* – RMO7,3,2
- u. *Status and nature of current relationship with family, friends and peers* – RMO7,4,1

- v. *Views of family and friends* – RMO7,3,1
- w. *Current attitude to offending* – RMO6,3,1
- x. *Insight into the illness* – RMO6,3,2
- y. *Behaviour that implies risk – though not inherently risky in itself* – RMO5,1
- z. *Severity of the index offence* – RMO4
- aa. *Views of victims* – RMO4,2
- bb. *Consideration of the subjective factors that might be influencing assessments (e.g. relationship with patient, personality of patient)* – RMO4
- cc. *HCR-20 scores* – RMO3
- dd. *Patient's views* – RMO2

1.3 HO risk assessment: includes risk to patient?

- a. *Includes consideration of risk to patient themselves* – RMO9, 7,3
- b. *Not about risk to patient at all* –
- c. *Risk to patient not mentioned* – RMO10, 11, 8, 6,5,4,2,1

2. RMO role

2.1. *Psychiatrists' role is to treat mental disorder primarily –concern with risk is secondary* – RMO9, 7, 6

2.2. *Psychiatrists' role – equal components – risk and therapeutic care of patient* – RMO4,1

3. Insight into mental illness – factors included in definition/factors looked for in clinical interview

- a. *Recognition of symptoms: ability to identify these experiences as symptoms of a mental illness* - RMO1,2,3,5,7,9,11,8,10
- b. *Understanding of illness and how symptoms will affect you* - RMO1,2,4,6,7,9
- c. *Understanding the need for medication and acceptance of this (compliance)* - RMO1,2,3,4,5,6,7,9,11,8,10
- d. *Understanding of previous treatment and need for treatment into the future*–RMO1, 4, 10
- e. *Understanding of the potential for relapse and recognition of signs of relapse* – RMO1, 2,6,9
- f. *Understanding of factors likely to prompt relapse* – RMO2, 5,7
- g. *Patients' behaviour demonstrates this understanding (e.g. avoidance of triggers)* = RMO2,9
- h. *Degree to which the patient's understanding of their symptoms and their meaning and their solution concurs with the doctor's* – RMO4
- i. *Patient' understanding of why they are in hospital* – RMO4
- j. *The 'way' in which a patient talks about issues related to his/her illness and the extent to which he/she can do it* – RMO4,9
- k. *Patient seeks help when they start to relapse – indicates good insight into MI* – RMO6,9

- l. Patient sees link between their illness and offending – RMO6,11
- m. Patient taking responsibility for medication indicates good insight – RMO6
- n. Insight into MI not absent or present – it is graduated – RMO6,7,11,8
- o. Insight into MI not static – patients can have it sometimes and not others – RMO8

4. Problems in the assessment of insight into MI

- a.** Difficulty of assessing some patients' honesty in clinical assessment – e.g. PD patients – RMO1, 2, 11
- b.** Increased difficulty for PD patients in achieving insight into their disorder as compared with patients who are mentally ill – RMO9
- c.** Patients with schizophrenic illnesses find it more difficult to develop insight, therefore complicating assessment – RMO2,8
- d.** Patients with 'neuroses' (e.g. OCD, phobias, depression) easier to assess in terms of insight into MI – RMO2
- e.** Patients who have been too long within forensic system may resign themselves to illness notion and therefore give a false impression of insight into MI – RMO2
- f.** Models about illnesses are culturally biased and make use of different language and explanations to many patients – therefore cause problems in assessment of insight – RMO4
- g.** Models about illness do not always accommodate the specific circumstances relevant to individuals, therefore cause problems for patients' understanding of the doctors' perspective and so affect judgements about insight – RMO4
- h.** Increased complexity of assessing insight in patients with learning difficulties - demonstrated over longer period of time through behaviour and relationships with staff RMO5
- i.** Difficulty assessing insight in patients who have poor memory of the circumstances surrounding the offence – RMO6
- j.** Difficulty assessing insight in patients who are guarded – RMO6

5. Relationship between insight into the offence and insight into the mental illness

1. *Insight into the offence = (a part of) insight into mental illness – 'where MI directly led to offence, you can't separate them very effectively'. RMO1,2,6,7,9,11,8*
2. *Insight into mental illness distinct from insight into the offending (you can have one without the other) RMO1,2,3,5*
3. *Insight into MI and offending distinct but related - not having insight into illness jeopardises the chances of having insight into the offence – RMO3, 5,4,10*
4. *Accepted understanding of insight into mental illness used explicitly as model for defining insight into offending behaviour – RMO3*

Appendix 8: Analysis – Examples of charted data

Insight into offending behaviour: Chart 1: Definitions given by HO participants (also factors looked for in assessment)

	1.1. Participant's definition	1.2 Relationship between insight into mental illness and insight into offending	1.3 How insight into offence is demonstrated behaviourally	1.4 How the term 'attitudes' in the context of offending behaviour relates to 'insight into offending behaviour'	1.5 Additional views on assessment of insight
HOCW1	No minimisation of offending behaviour (p. 51) Ability to empathise with victim and understand how offence affected them (p.51) Taking responsibility for the offence (p.51, p.24) Understanding of relationship between mental illness and the offending (p.55, p.44)	Insight into offence is part of insight into mental illness – patient understands they have a mental illness and how it led to the offence (p.55, p.44) Part of the illness can be the offending behaviour, so insight into illness leads to insight into the offending behaviour (p.91)	Proving they understand through change of behaviour - e.g. not drinking, (p. 67), taking medication (p. 55)	Term 'attitudes' interchangeable with insight: questions about insight and attitude are tapping same information (p.50-55) Term 'attitudes' in this context also tapping into information about insight into mental illness – because two forms of insight are linked (p.55)	Assessment of insight is an entirely clinical matter – not in the remit of HO staff (p.63,p.59p.104-6))
HOCW2	No minimisation of offending behaviour (p.24) Ability to empathise with victim and understand how offence affected them (p.22) Expression of remorse (p.22) Understanding how offending has affected patient's own life (p.24) Self-awareness (p.22, p.64) Ability to understand and rationalise offending behaviour –how it came about (p.64, 92)	Insight into the illness is distinct from insight into offending (p. 62)	Proving they understand through change of behaviour - e.g. not obtaining drugs, avoiding provocation, peer group (p.30, p.90, p. 92) Consistency between what is said in therapy and what is said outside that context (p.26) How a patient responds to ground leave – 'not pushing boundaries' (p.32) Absence of insight demonstrated by contradictory statements, boasting.	Term 'attitudes' interchangeable with insight: questions about insight and attitude are tapping same information (p.22, 23, 24)	

HOCW3	<p>Clear cognitive model of offending – factors involved, how they led to offence and consequences (p.45)</p> <p>Understanding how to prevent reoccurrence (p.45)</p> <p>Understanding of relationship between mental illness and the offending (p.45)</p> <p>Ability to empathise with victim and understand how offence affected them (p.47, 53)</p> <p>Understanding how offending has affected patient's own life (p.53)</p> <p>No minimisation of offending behaviour (p.105, 106)</p> <p>Remorse and regret (p.45)</p>	<p>Insight into offence is part of insight into mental illness – patient understands they have a mental illness and how it led to the offence: no insight into illness means no insight into the offending (p.97, p.106, p.112)</p>	<p>minimising (p.26)</p> <p>Sounding genuine (what patient quoted as saying sounds consistent with the way they normally speak – not rehearsed) (p.67)</p> <p>Proving they understand through change of behaviour (p.106)</p>	<p>Refers to the emotional aspects of insight into offending: specifically remorse and empathy. Attitudes = remorse and empathy = one part of insight into offending (p.37, 47)</p>	<p>Insight into offending behaviour is easier to assess in mentally ill (psychotic patients) compared with psychopaths because they are better able to present 'false insight' (p.51)</p>
HOCW4	<p>Acceptance of the offence (p.25)</p> <p>Understanding of the relationship between the mental illness and the offending (p.25)</p> <p>A clear, cognitive model of offending – factors involved, how they led to the offence</p>	<p>Insight into the illness is distinct from insight into offending – you can have insight into illness without insight into the offence (p.65, 31)</p>	<p>Demonstrated through 'responsible behaviour' e.g. engagement in treatment, compliance with medication, behaviour during ground leave (p.29)</p> <p>Sounding genuine (what patient quoted as saying sounds consistent with the</p>	<p>All-encompassing term: refers to emotional responses (regret, sympathy, empathy) to offending, AND insight into illness AND insight into offending (p.19)</p>	<p>Patients with psychopathy and PD are better able to present 'false insight' thus making assessment of insight more difficult (p.33)</p>

	and consequences (p.25) Understanding how to prevent reoccurrence (p.25)		way they normally speak – not rehearsed (p.79)		
HOCW5	Understanding of the relationship between the mental illness and the offending (p.47) Remorse and regret (p.38, p.12) Understanding of how to prevent reoccurrence and willingness to engage in treatment aimed at prevention of reoccurrence (p.38-39)	Insight into offending is part of insight into mental illness as demonstrated through acceptance of role of illness in offending, and compliance with medication and treatment plan (p.47, p.36) Not possible to separate the two constructs very effectively (p.14)	Demonstrated through compliance with treatment plan and medication (p.47, p.36) Consistency of accounts of patients given by professionals (p.15,p.20)	Questions about attitude are asking about compliance with treatment plan designed to manage risk, and signs of responsible behaviour (e.g. managing own medication). (p.9, 10) All-encompassing term: refers to emotional responses (regret, sympathy, empathy) to offending, AND insight into illness AND insight into offending (p.11, 13-14)	Level of difficulty of decision-making with regards to insight into offending indicates level of risk (p.48) Patients with mental illness are easier to assess in terms of insight into offending compared with patients with PD (p.13) Assessment of insight is an entirely clinical matter – not in the remit of HO staff (p.12, p.14)
Head of Unit (HOCW 6)	N/A	N/A	N/A	N/A	N/A

Insight into offending behaviour: Chart 4: Definitions given by RMOs (also factors looked for in the assessment of insight)						
Participant	1.1 Participant's definition	1.2 Relationship between insight into mental illness and insight into offending	1.3 How insight into offending is demonstrated behaviourally	1.4 Clinical assessment of insight	1.5 How the term 'attitudes' in the context of offending behaviour is related to 'insight into offending behaviour'	1.6 Areas of difficulty in working to promote insight and/or assessment of insight into offending
RMO1	<ul style="list-style-type: none"> -Accepting the offence took place (p6) -Understanding moral gravity of the offence (p6) -Wishes not to re-offend in the future -Understanding of factors involved in the offence – how it came about (p6) -Understanding how to avoid re-offending by avoidance of identified triggers/stressors (p6) -Concurrence with doctor's view of the offence and how it came about (p6) 	<ul style="list-style-type: none"> -Insight into the offence and insight into mental illness are 'interlinked' where mental illness directly led to the offence. (p34) -Insight into mental illness is distinct from insight into offending – you can have one without the other (p 9, 10,34) 	<ul style="list-style-type: none"> -Behaviour on ward/leave (changed functioning and absence of risky behaviours) (p11, 8) -Compliance with offence-related work and medication (p8) -Consistency of behaviour displayed across time and settings 	<ul style="list-style-type: none"> -Evaluated through the development of a model of offending and the degree to which patient can accept and work with this -Consistency of attitude and sentiments expressed across time and with different professionals (p9) 	<ul style="list-style-type: none"> -Terms used interchangeably – refer to same construct (see p6&p7) 	<ul style="list-style-type: none"> -Assessment more difficult in patients suffering with amnesia (p42) -Assessment more difficult in cases where offending was not related to mental illness/disorder (e.g. patients transferred to RSUs from prisons) -Assessments more difficult in patients with PD and others less likely to talk honestly about their experiences (p 21)
RMO2	<ul style="list-style-type: none"> -Taking personal responsibility for the offence (p36) -Accepting the offence took place (p6) -Understanding moral gravity of the offence (p36) -Understanding factors involved in the offence – how it came about (p6) -Understanding how to avoid re-offending by avoidance of identified triggers/stressors (p6) 	<ul style="list-style-type: none"> -Insight into the offence is part of insight into mental illness: patient understands how mental illness led to the offence (p17,p.21) -Insight into mental illness is distinct from but related to insight into offending – you can have one without the other and they are assessed separately (p34) 	<ul style="list-style-type: none"> -Compliance with offence-related work and medication (p.9, 10) -Behaviour on ward/leave (changed functioning and absence of risky behaviours) (p10) -Consistency of behaviour displayed across time and settings 	<ul style="list-style-type: none"> -Evaluated 'intuitively' in clinical interview – how 'genuine' or engaged a patient seems when talking about the offence (p7,8,36,39) -Consistency of attitude and sentiments expressed across time and with different professionals (p8) -Views of other professionals involved in care important (p14) -Psychometric assessment can be helpful (e.g. HCR-20) (p7) 	<ul style="list-style-type: none"> -Terms used interchangeably – refer to same construct with addition of emotional responses to the offence (remorse and empathy) (p5&6) 	<ul style="list-style-type: none"> -Insight more difficult for patients with LD to achieve (p.23) -Insight more difficult for patients with PD and schizophrenia to develop (p21)

RMO3	<p>-Understanding factors involved in the offence (p26)</p> <p>-Concurrence with doctor's view of the offence and how it came about (p26, 28)</p>	<p>-Insight into offending explicitly 'modelled' on accepted models of insight into MI – see p28)</p> <p>-Insight into mental illness is distinct from insight into offending – you can have one without the other (p31 'they are dissociable')</p> <p>-Insight into mental illness and offending are distinct but related – not having insight into mental illness jeopardises the chances of having insight into the offence because they involve the same cognitive processes (p 30,31)</p>	<p>-Behavioural assessment is NOT a reliable measure of insight – a patient can have insight but not enough willpower to resist stressors/triggers. These are two distinct mechanisms (p28,31)</p>	<p>-Evaluated through the development of a model of offending and the degree to which patient can accept and work with this (p28)</p> <p>-Evaluated 'intuitively' in clinical interview – how 'genuine' or engaged a patient seems when talking about the offence (p27,37,38)</p> <p>-Views of other professionals involved in care important (p27)</p>	<p>-Terms used interchangeably – refer to same construct (p24)</p> <p>-Also refer to the 'types' of attitudes held generally around the offence – are they pro- or anti-social and therefore indicate continued tendency towards offending? (p 24-25)</p>	<p>-Insight more difficult to achieve for patients with Asperger's Syndrome (p58)</p> <p>-Assessment more difficult where patient has a history of lying (p45)</p> <p>-Assessment more difficult in chronically substance-misusing patients (p46)</p>
RMO4	<p>-Taking personal responsibility for the offence (p10)</p> <p>-Understanding the effect of the offence on the victim (empathy) (p 10)</p> <p>-Understanding moral gravity of the offence (p11) (p49)</p> <p>-Wish not to re-offend in the future</p> <p>-Remorse (p10)</p> <p>-Understanding factors involved in the offence (p 10)</p> <p>-Understanding how to avoid re-offending by avoidance of identified triggers/stressors (p 10)</p> <p>-Concurrence with doctor's view of the offence and how it came about (p32)</p> <p>-Recognition of the relationship between the illness and the offending (p48)</p> <p>-Ability to see signs of illness relapse as indication of</p>	<p>-Insight into mental illness and offending are distinct but related (implied) – not having insight into mental illness jeopardises the chances of having insight into the offence (p 13)</p>	<p>-Compliance with offence-related work (p 11)</p> <p>-Behaviour on ward/leave (changed functioning and absence of risky behaviours)</p>	<p>-Important to consider the influence that a doctor's/team's relationship with the patient/personal response to the patient's personality has on the assessment (p24-25-26, p.27)</p> <p>-Evaluated through the development of a model of offending and the degree to which patient can accept and work with this (p 11) (p32) (p 49)</p> <p>-Evaluated 'intuitively' in clinical interview – how 'genuine' or engaged a patient seems when talking about the offence (p15,17)</p>	<p>-Terms used interchangeably – refer to same construct (p 9,p 10)</p> <p>-Also refers to the 'types' of attitudes held generally – are they pro- or anti-social and therefore indicate continued tendency towards offending?</p> <p>-Realism of self-assessment with regards to future offending (p 9)</p>	<p>-Assessment more difficult where patient has a history of lying (p37,51)</p> <p>-Assessment not possible where a patient remains chronically ill and has limited communication (p.37)</p> <p>-Assessment more difficult in cases where offending was not related to mental illness/disorder (e.g. patients transferred to RSUs from prisons) (p12)</p> <p>-Assessment more difficult in patients who are from different cultural backgrounds to the Western one from which models of insight etc derive (p 37)</p>

RM05	<p>potential for re-offence and seek help (p.48)</p> <ul style="list-style-type: none"> -Taking personal responsibility for the offence (p 6) -Accepting the offence took place (p6) -Understanding the impact of the offence on the victim (empathy) (p6) -Understanding the impact of the offending behaviour on society (p7) -Insight into offending is graduated: there are degrees to which a patient possesses it (p27) -Understanding factors involved in the offence (p 6) -Awareness of unconscious processes involved in offending (p6) - Recognition of the relationship between the illness and the offending (p6) -Understanding of how offence related to own personal and psychological issues (p35) 	<ul style="list-style-type: none"> -Insight into mental illness and offending are distinct but related – not having insight into mental illness jeopardises the chances of having insight into the offence but you can have one without the other (implied – p 36-37) 	<ul style="list-style-type: none"> -Consistency of behaviour displayed across time and settings (p8, 10) -Congruency of what patient says with how they behave (p10) - Behaviour on ward/leave (changed functioning and absence of risky behaviours)(p 11) 	<ul style="list-style-type: none"> -Consistency of attitudes and sentiments expressed across time and with different professionals (p8) -Views of other professionals involved in care important (p8) 	<ul style="list-style-type: none"> -Denotes the overall 'thinking style' around the offence – referring to the 'types' of attitudes held generally: positive/negative feelings about it/ pro- or anti-social attitudes held (p5) 	<ul style="list-style-type: none"> -Insight more difficult to achieve for patients with LD (p19) -Assessment more difficult in patients with LD (p21)
RM06	<ul style="list-style-type: none"> - Understanding moral gravity of the offence - Understanding factors involved in the offence (p7) - Understanding how to avoid re-offending by avoidance of identified triggers/stressors (p7) - Recognition of the relationship between the illness and the offending (p7) - Ability to see signs of illness relapse as indication of potential for re-offence and seek help (p7,17) -Insight into offending is 	<ul style="list-style-type: none"> -Insight into the offence part of insight into mental illness – you cannot have the former without the latter where mental illness directly led to the offence (p15-16) 	<ul style="list-style-type: none"> -Compliance with offence-related work and medication (p9) - Behaviour on ward/leave (changed functioning and absence of risky behaviours (p10,p17) 	<ul style="list-style-type: none"> -Evaluated through the development of a model of offending and the degree to which patient can accept and work with this -Evaluated 'intuitively' in clinical interview – how 'genuine' or engaged a patient seems when talking about the offence (p17) -Patient's 'openness' key in the assessment procedure (p17) - Views of other professionals involved in 	<ul style="list-style-type: none"> -Refers to the emotional responses to the offence (regret, remorse, empathy)(p6) - Denotes the overall 'thinking style' around the offence – referring to the 'types' of attitudes held generally: positive/negative feelings about it/ pro- or anti-social attitudes held (p6) 	<ul style="list-style-type: none"> -Insight more difficult for patients who were floridly ill at time of the offence and so have little memory of the events leading up to it and the offence itself (p19) -Assessment of insight is more difficult where patients are guarded (p.19,35)

RM07	<p>graduated, there are degrees to which a patient possesses it (p18)</p> <ul style="list-style-type: none"> - Faking personal responsibility for the offence (p9) - Understanding the impact the offence had on the victim (empathy) (p9,16) - Understanding the impact the offence had on society - Understanding moral gravity of the offence (p9,10) - Wishes not to re-offend in the future (p9) - Remorse (p8) - Insight into offending graduated – there are degrees to which a patient possesses it - Understanding of the impact offence had on patient's own life (p9) - Recognition of the relationship between the illness and the offending (p10) 	<ul style="list-style-type: none"> - Insight into the offence part of insight into mental illness – you cannot have the former without the latter (p35) 	<ul style="list-style-type: none"> - Behaviour on ward/leave (changed functioning and absence of risky behaviours) (p16, p15) - Consistency of behaviour displayed across time and settings (p16) - Compliance with offence-related work (p19) 	<p>care important (p9)</p> <ul style="list-style-type: none"> - Important to consider the influence that a doctor's/team's relationship with the patient/personal response to the patient's personality has on the assessment - Consistency of attitudes and sentiments expressed across time and with different professionals (p16) - Views of other professionals involved in care important (p16-17) 	<ul style="list-style-type: none"> - Terms used interchangeably – refer to same construct (p8) - Refers to the emotional responses to the offence (remorse specifically) (p8) 	<ul style="list-style-type: none"> - Assessment more difficult in patients with LD (p11), in patients with PD (p24), and in patients with organic conditions (brain injury) (p24) - Assessment can be easier in patients with LD – they are less able to learn responses and therefore give false impression of insight when it is absent (p15)
RM08	<ul style="list-style-type: none"> - Insight into offending graduated – there are degrees to which a patient possesses it (p7,8,10,11) - Insight into the offence is dynamic – sometimes patients can have it, sometimes they don't (p10) - Understanding factors involved in the offence (p9) - Understanding how to avoid re-offending by avoidance of identified triggers/stressors (p13) - Insight into the offence is about the ability to stand back and look at yourself objectively (p24,26) 	<ul style="list-style-type: none"> - Insight into the offence part of insight into mental illness – you cannot have the former without the latter (p12, p14) 	<ul style="list-style-type: none"> - Behavioural assessment is NOT a reliable measure of insight – a patient can have insight but not enough willpower to resist stressors/triggers. These are two distinct mechanisms (p.13,17) 	<ul style="list-style-type: none"> - Evaluated 'intuitively' in clinical interview – how 'genuine' or engaged a patient seems when talking about the offence (p12-13,14) 	<ul style="list-style-type: none"> - Refers to the emotional responses to the offence (regret, remorse, empathy) (p7,8,10) 	<ul style="list-style-type: none"> - Very few patients can achieve insight into offending – so doesn't expect this of them (p14,21) - Insight universally difficult to achieve both for patients and non-patients (p17,24,26)

	<p>place (p13)</p> <ul style="list-style-type: none"> -Understanding the impact the offence had on the victim (empathy) (p13) -Understanding the impact the offence had on society (p13) - Understanding moral gravity of the offence (p11,16) -Wishes not to re-offend in the future (p13,p14) -Remorse (p14,p15,17) - Insight into offending graduated – there are degrees to which a patient possesses it (p14) - Understanding of the factors involved in the offence (p23,50) -Understanding of how to avoid re-offending by avoidance of identified triggers/stressors(p23) - Concurrence with doctor's view of the offence and how it came about (p24) 	<p>them very effectively (p23,28-29)</p>	<p>(p21,25)</p> <ul style="list-style-type: none"> -Congruency of what a patient says with how they behave (p25) -Behavioural assessment is NOT always a reliable measure of insight – a patient can have insight but not circumstances weaken their ability to resist stressors/triggers (p43) 	<p>which patient can accept and work with this (p24)</p> <ul style="list-style-type: none"> -Evaluated 'intuitively' in clinical interview – how 'genuine' or engaged a patient seems when talking about the offence (p48) 	<p>-Terms used interchangeably – both refer to same construct (p11)</p>	<p>the time of the offence, for patients with Asperger's Syndrome (p41) and for patients who cannot emotionally accept their offence (p49)</p>
--	--	--	---	---	---	--