

Mad or Bad?

• A Critical Approach
to Counselling and
• Forensic Psychology

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1

WORKING THERAPEUTICALLY IN FORENSIC SETTINGS

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Image 1 Mad or bad head. With permission, Sue Cheval

Introduction

The question of whether a person is 'mad' or 'bad' is not a new one and has concerned thinkers, policy-makers, judges and doctors throughout history. However, changes in mental health and the prison service since the nineteenth century have accentuated the 'mad or bad?' debate and led to a profound shift in the way people with mental health problems are treated legally and judicially (see Chapter 2 for an overview of historic developments). At the heart of this debate is the relationship between personal responsibility, accountability and criminal behaviour, culminating in the question: should someone with mental health problems be considered as fully responsible and culpable for their offences?

From a legal perspective, the issue might seem clear and straightforward at first sight. In the UK, and other Western countries, an offender's inability to distinguish between right and wrong and to form intent, due to a lack of mental facility, necessitates a verdict of diminished criminal responsibility, not guilt. Furthermore, under the 1983 Mental Health Act (amended in 2007) courts have the possibility, if there is the assumption of a diminished legal responsibility at conviction, to recommend detention and treatment in a secure hospital rather than a prison sentence (Davies & Doran, 2012). However, not only can it be very difficult to establish a clear relationship between the mental state at the time of the offence and the offence itself, research also suggests that the public are often not sympathetic to pleas of insanity in mitigation of commission of a crime as 'there is a perception that the insanity defense is morally questionable and exploits a legal loophole' (Gans-Boriskin & Wardle, 2005, p. 31).

In this chapter we take a closer look at how tensions related to the 'mad or bad?' debate surface in the practices at the interface of mental health and criminal justice – a working environment that has been described as among the most challenging for either set of professionals (Peay, 2010). The debates here are around the questions of whether a forensic setting is principally counter-therapeutic and if therapeutic and forensic agendas (promoting well-being vs. preventing re-offence) can be compatible. The chapter will set the scene for the book in comparing aims and agendas of therapeutic and forensic services and the ways in which issues such as risk, consent, disclosure and power are seen and dealt with in therapeutic and forensic settings.

Pause for reflection: Mad or Bad?



Reflect on your own position in the 'mad or bad?' debate: Should someone who has mental health problems be held fully responsible and accountable for their offences, or not, and how should they be treated?

Working in therapeutic and forensic settings

Before exploring the underlying differences and tensions in terms of the values, cultures and practices developed in the fields of counselling psychology and forensic psychology, it is useful to establish what exactly constitutes a 'therapeutic' and 'forensic setting'. This will perhaps not be as straightforward as you might expect as it can be difficult in practice to differentiate between a therapeutic and non-therapeutic setting and a forensic and a non-forensic setting (Rogers, Harvey & Law, 2015). For example, it is debatable whether preventative community programmes with young people who are considered as being at high risk of harming themselves or others constitutes a forensic setting.

Classic psychotherapeutic settings include private practices, where therapy is offered at a therapist's home or in private practice rooms, counselling agencies, and therapy services offered in the context of the National Health Service (NHS) in the UK (like 'Improving Access to Psychological Therapies' (IAPT) services). In other less traditional therapeutic settings, like for example counselling in schools or workplace 'employee assistance programmes', counsellors may work with people who do not always come of their own volition – an issue we will discuss further below. Technology-based services, like telephone and online counselling, are provided in settings beyond the classical face-to-face, one-to-one encounter between client and therapist.

There are a number of different types of forensic setting, the most obvious example being prisons. Prisons have different levels of security, depending on the level of risk the prisoner poses to public or national security, and range from Category A for prisoners deemed to pose the most risk to Category D 'open' prisons. In Scotland there are high, medium and low supervision categories and the Governor decides what category a prisoner will be. Women and young offenders are not assigned the same categories and are simply allocated either closed or open conditions in the UK. Offenders aged between 15 and 18 years are sentenced to Young Offender Institutes (YOI), which have regimes very similar to adult prisons.

There are also secure hospitals where individuals will be admitted and detained under the Mental Health Act. The decision to admit an individual to a secure hospital will be based on a comprehensive risk assessment and detailed consideration of how the risks identified can be safely managed while in hospital (NHS Commissioning Board, 2013). Many, but not all of those admitted to High Secure Services, will have been in contact with the criminal justice system and will have either been charged with, or convicted of, a violent criminal offence. High-security hospitals play a key role in assessing an individual's ability to participate in court proceedings and in providing advice to courts regarding disposal following sentencing.

Table 1.1 Brief institutional profile of a therapeutic and forensic service

Institution	Tavistock Relationships (TR) in London*	HMP Woodhill**
Description	<p>TR was formed in 1948 and provides a range of counselling and psychotherapy services which support clients experiencing challenges in their relationships, their sexual lives and parenting. The services are offered on a sliding scale according to client income. TR also provides professional training and continuous professional development (CPD) for relationship therapists.</p> <ul style="list-style-type: none"> – Increase the availability of relationship support so every couple can access help when they need it. – Provide affordable, accessible and evidence-based psychotherapy services in a safe, confidential and non-judgemental environment. – Help partners to understand each other better and work through their relationship problems. 	<p>HMP Woodhill is a Category A male prison, which first opened in 1992 serving courts across the Thames Valley Region as well as Northamptonshire. It has a capacity of 819 and has both single and dual occupancy cells. In 1998 one wing was re-designated as a close supervision centre, which holds a small number of prisoners who are among the most difficult and disruptive in the prison system.</p> <ul style="list-style-type: none"> – Incarcerate offenders whose escape would be highly dangerous to the public, the police or to the security of the State for the term of their sentence. – Provides a recovery focused treatment for substance misuse problems. – A minority of inmates might also receive courses in enhanced thinking skills, relationships and life skills.
Main aims and objectives	<p>Clients are from all types of background, age and culture. In 2015 nearly 3,500 people were seeking help at TR for relationship difficulties, parenting problems and issues around sex life. 71% of clients are suffering from mild, moderate or severe depression at their first visit (with 56% of clients 'recovering' from their depression by the end of therapy).</p>	<p>Category A male prisoners as well as foreign nationals awaiting deportation. Category A prisoners are the most dangerous prisoners and deemed to be the most at risk to the public. The types of offence inmates may have committed include murder, manslaughter, rape, indecent assault, firearms offences, class A drug offences and offences connected with terrorism.</p>
Clients		

*Source: TR Annual Review 2015 and www.tavistockrelationships.org; **Source: www.justice.gov.uk/contacts/prison-finder/woodhill

To illustrate the values, aims and agendas in therapeutic and forensic settings Table 1.1 provides you with the examples of two institutional profiles – one located in a traditional therapeutic context and the other one in a classical forensic setting.

Comparing these two institutional profiles helps to understand the differing and sometimes competing aims and agendas of services operating in the mental health and criminal justice system.

- In the mental health system, including therapeutic services, the central aim is to help clients/patients who are in distress and promote their individual well-being. Hence, the main focus of practitioners in therapeutic settings is the work with the psychological needs of individuals.
- In contrast, work in a forensic setting often seems dominated by the need to provide security and protection for the public. Punishment and rehabilitation of the offender, with the main purpose to prevent re-offending, are the central goals in the criminal justice system, especially in a secure prison context. Specifically helping individuals with their personal problems and mental health issues does not always seem a top priority in this context (Smedley, 2010).

The comparison illustrates how much the setting of a prison or medium secure hospital differs from the contexts in which most psychotherapy is conducted in the mental health system. The difference in values and agendas can be understood as a reflection of the 'mad or bad?' debate (mad – treatment, bad – punishment and protection of the public) and often lead to tensions for mental health practitioners working therapeutically in forensic settings. They can find themselves at odds with the prevailing institutional values and fundamental aims as well as the professional mindset of their forensic colleagues (e.g. prison officers). They might also find themselves in a dual professional position where they are expected to focus on both the specific needs of their clients as well as risk management and protection of the public – two aims that are not always easily compatible, as we will see in this book.

Before we explore the issues and challenges of working therapeutically in forensic settings in more depth you might want to know what kind of therapeutic practitioners and related professionals work with mental health issues in these settings. Information box 1.1 provides you with an overview of the main professional groups that are employed in forensic services to work with these issues.

Information box 1.1: Professionals working with mental health problems in forensic settings

Counsellors/Psychotherapists

These two professional groups are quite similar, although often psychotherapists are trained more extensively (and to postgraduate level) whereas counsellor training can include training courses at Diploma, Degree or Masters level. Both use therapeutic skills and techniques (which approach they follow depends on their training, see Chapters 13–16) to help clients with their problems. Currently counselling and psychotherapy are not regulated in the UK, meaning there are no minimum requirements to practice, and no laws preventing anyone calling themselves a counsellor/therapist. However, most reputable counsellors/therapists will be registered with a professional organisation and meet the relevant standards for registration regarding training and supervision. The psychological therapists' register of the British Association for Counselling and Psychotherapy (BACP) was the first to be accredited by the Professional Standards Authority (PSA) for Health and Social Care, an independent body accountable to the government in the UK. BACP registered practitioners must also abide by the ethical and professional standards of the professional body.

Practitioner Psychologists

Through first studying a British Psychological Society (BPS) accredited undergraduate psychology qualification, which provides Graduate Basis for Chartered membership (GBC), Practitioner Psychologists then complete a postgraduate training programme (usually taking three years) in one of seven areas of applied psychology. The following three areas are particularly relevant for therapeutic work in forensic settings:

- *Counselling and Clinical Psychologists*: These are both trained to doctoral postgraduate level and are the main professional groups providing psychological therapy in forensic settings. As a broad and general distinction, Clinical Psychologists will often be trained in cognitive behavioural therapy and work briefly with clients whereas Counselling Psychologists tend to work from a humanistic philosophy and integrate different therapeutic approaches dependent on the client's needs.
- *Forensic Psychologists*: While many Forensic Psychologists are employed by the UK Prison service, they can also be found working in probation services, secure hospitals and other forensic services (Lantz, 2011). They are trained to Masters level at a minimum and work, for example, on the development and provision of treatment programmes for offenders, advise parole boards, and give evidence in court processes.

Forensic Psychiatrists

These are medically qualified doctors who have specialised in forensic psychiatry. Their work includes the assessment and psychiatric treatment of offenders with mental health problems in prisons, secure hospitals and the community. They often work with more severe mental health problems, and as medical doctors they can prescribe drugs. They have a good understanding of criminal, civil and case law relating to patient care in forensic settings and are often involved in risk assessment (e.g. in cases of violent or self-harming patients).

A good starting point for our exploration of therapeutic work in forensic settings is the list of challenges in providing therapy in a custodial setting (like a prison) outlined by Smedley (2010). It includes practical problems that can make it impossible for prisoners to attend therapy sessions (e.g. because they are 'locked down' due to security concerns) or lead to a disruption or abrupt termination of the therapy process (e.g. if the prisoner is moved to another prison). The author also refers to the fact 'that demand for mental health assessment and interventions in the prison far outstrips supply' (p. 94). Other challenges are the lack of opportunities for practitioners to have team discussions and peer support and the lack of privacy for their clients, which may impede confidentiality. Confidentiality – the general principle in therapy that everything disclosed by the client will be treated as confidential and kept private – might also be impeded in situations when therapists, under prison rules, are obliged to disclose information related to security risks that emerge in therapy sessions to the prison authorities. In the following section we will take a closer look at four particularly important themes and challenges of working therapeutically in a forensic setting.

Common themes and challenges of therapeutic work in forensic settings

The issues in this section are relevant for counsellors and psychotherapists in general, not only when working in forensic settings. However, in a forensic setting they often appear in an aggravated form, posing specific challenges and dilemmas for therapeutic and forensic professionals to navigate. When discussing these issues in the following, we will first outline their general significance in the therapy world before considering how they play out specifically in a forensic setting.

Risk and security

Issues around risk and security can be seen as one of the elephants in the therapy room – although these themes are ever present and inherent to any therapeutic work, they don't often surface in the discourse around therapeutic practice. This might have to do with the fact that it is fortunately rare that therapeutic practitioners are physically or sexually attacked or harassed by their clients (Bond, 2010). Nonetheless, the specific set-up of the therapy situation – with both therapist and client previously unknown to each other – inevitably entails elements of risk and unpredictability for both sides. For example, clients can run the risk that their symptoms might worsen during the therapy process (5–10% deteriorate during counselling or psychotherapy; Cooper, 2008), and a small minority might also find themselves harmed and damaged by the sexual misconduct of their therapist (see Chapter 10). Therapists, particularly those seeing clients on their own in private practice and in their homes, are generally vulnerable to physical or sexual assault and offences by their clients.

Hence, for Bond (2010), part of the ethical responsibility to oneself as a practitioner is to take precautions and organise the therapeutic work in ways to reduce risks. Therapists should ensure they speak on the phone to the client before the first therapy session to make a preliminary assessment. In the therapy room they could install a telephone with an outside line, or an alarm or 'panic button'. Therapists can increase security by having colleagues or a receptionist in the same building when seeing clients (often the case when working for an agency or therapy centre). Many organisations have implemented policies and procedures for risk assessment and management (e.g. assessment tools to capture risk information; Johnstone & Gregory, 2015). However, there can be 'tensions between organisational perspectives on risk and the perspectives held by practitioners and clients' (Melville, 2012, p. 24) when adhering to organisational procedures threatens to restrict confidentiality and to impede the therapeutic relationships. Despite possible precautions, practitioners might still experience a sense of danger in certain situations (e.g. when affected by the client's sense of threat to themselves) which can impact on their ability to work creatively with this client. In cases where it is impossible to restore a sense of personal safety (e.g. through supervision) it is seen as good and ethically sound practice to refer the client to another practitioner or agency (Bond, 2010).

In forensic settings practitioners won't be able to escape the themes of risk and security as they are a dominating contextual factor in this working environment (Logan & Johnstone, 2013). Risk assessment and security considerations will inevitably influence treatment planning

and interventions and will also have an impact on the therapeutic relationship between therapist and client (Davis, 2012; Harvey & Smedley, 2010). Within the prevailing risk discourse, offenders are to some extent considered as a continued security risk due to their violent and/or criminal history ('the past is the best predictor of the future') and diagnostic categorisations implying volatility and potential risks (Melville, 2012). Dependent on the client's individual security classification, therapists will need to follow certain security protocols when offering therapy sessions in secure settings. Being aware of the client's criminal record and offence, they may also have to deal with their anxiety levels about potential violence during therapy sessions, and seek support in supervision if they feel impaired by their fears. If they feel appalled by the offence committed by their client, it will be challenging to offer therapeutic intimacy and to develop an accepting stance towards the person - without accepting the offence (Davis, 2012). You will hear more about how the therapeutic relationship is affected by risk and security considerations, and the institutional environment in forensic services more generally, in the chapters in the 'Treatment' part of this book and in Chapter 19 on 'Contexts'.

Consent

In addition to safety, confidentiality, and the avoidance of exploitation, a key ethical principle across counselling, psychotherapy and counselling psychology is that therapy is a voluntary endeavour which clients freely choose to engage in (Bond, 2010). This is part of the ethical principle of autonomy or respect for the client's right to be self-governing (British Association for Counselling and Psychotherapy, 2016b). Another way of putting this would be to say that clients need to provide their consent to engage in therapy. Under UK law consent is defined as being present if a person agrees to something by choice and has the freedom and capacity to make that choice (see Chapter 9). Capacity means that they need to be in a mental state where they are capable of making a rational decision (e.g. not drunk or intellectually impaired), and also that they need enough information with which to make the decision (e.g. about what therapy will actually involve). Consent is highly related to power, which we will come to in a moment, because it is very hard to freely consent to something if you have far less power in the situation than the other person, for example if you feel like the therapist is pressuring you to attend.

Consent should be dealt with in therapy through the making of a contract between client and therapist (Bond, 2010). This usually happens in the first session but may be revisited through the sessions.

In the contract, the therapist should make it clear to the client what their form of therapy involves (so that they can make an informed choice about whether it is for them) and any boundaries around time, space etc. They should also stress that the client is at liberty to stop coming to therapy at any point. This is vital because the most important factor in determining the success of therapy is the therapeutic relationship (Cooper, 2008), so clients need to feel able to move to a different therapist if they do not feel a good rapport. In regular counselling and therapy there are actually many circumstances in which a client may not be able to give informed consent, for example if this counsellor or form of therapy is the only one available to them where they live, or for a price they can afford; if they are being pressured to attend therapy by an employer or teacher due to organisational or school policies; or if the client has been in therapy for a while and simply does not feel able to tell the therapist that it is not working for them anymore. In all of these situations it behoves the therapist to work with the client in order to reach a point where they are freely consenting to be there, and would feel able to stop coming if that was in their best interests.

Of course, consent is likely to be an even more complex issue within forensic contexts. Therapeutic work in such settings usually requires the consent of the service user – as with any therapy – but this may not always be possible, for example in situations where attending one-to-one or group therapy is part of the sentencing. Under such circumstances the service user is not freely consenting to therapy because they are forced to be there. There are also issues in situations where service users know – or believe – that attending therapy might get them time off their sentences, in which case they will feel under pressure to attend. Many authors stress the importance of therapeutic roles being kept very separate from forensic roles, for these kinds of reasons (Greenberg & Shuman, 1997). However, there will still be challenges for practitioners working with service users who are pressured or forced to attend therapy (see also Chapter 19).

Self-disclosure

Clients' self-disclosure is a central feature of counselling and psychotherapy processes, and human relationships more generally, with potentially positive effects on psychological health and well-being (Forrest, 2010). Therapeutic work is reliant on clients opening up and sharing their thoughts and feelings so that the therapist can develop an understanding of the client's situation and provide suitable interventions. In psychotherapy research, client engagement and involvement, including self-disclosure, have been identified as one of the factors

clients contribute to a successful psychotherapy process and outcome (Bohart & Wade, 2013; Tyron & Winograd, 2011). Talking about previously unrevealed experiences and related feelings can increase trust and help to build a strong therapeutic relationship, provided the therapist responds adequately to the disclosures (Fitzpatrick, Janzen, Chamodraka & Park, 2006).

There are a number of individual factors that can influence a client's ability or willingness to self-disclose in therapy. For example, people might find it generally difficult to trust others and disclose their feelings if they had traumatic or abusive relationships in the past (Harvey & Endersby, 2015). Saypol and Fraber (2010) found that clients with a fearful attachment style (a general way of relating to other people; see Chapter 13) tend to disclose less and also feel less positive about the disclosure of unrevealed material in therapy. Mental health problems, like depression or anxiety, can affect both the level and content of client disclosure in therapy. Finally, and particularly with highly stigmatised material, if and how much a client is willing to share will also depend on the anticipated level of shame and vulnerability when disclosing (Farber, Berano & Capobianco, 2004).

Pause for reflection: Self-disclosing in a forensic setting



Imagine that you are an inmate in a high-security prison. How would you feel about disclosing your violent thoughts and fantasies (towards yourself and inmates) to your therapist, knowing that they are obliged to pass on information related to security risks to the prison authorities?

In forensic settings, like prisons or secure hospitals, disclosing is a much more complex process. In addition to the individual factors discussed above, the decision to share difficult material with the therapist is here affected by specific contextual factors. These are environments in which inmates learn for their own safety not to show weaknesses or vulnerabilities to peers and officers. This is often paired with a culture in which 'grassing' on other inmates is a taboo – both factors that can make it more difficult to open up and talk about experiences of, for example, bullying or violence (Crewe, 2009). Clients are also aware of the confidentiality limitations and the therapist's obligation to pass on risk-related information, which means that client's disclosure in therapy can have negative consequences for their own liberty (e.g. when monitored or their leave is cancelled due to safety considerations;

Harvey & Endersby, 2015). Hence, it would be short-sighted to always see it as a sign of lacking therapy motivation if clients are reluctant or unwilling to disclose. Rather, they have to make pragmatic decisions considering the potential short- and long-term costs and benefits of a disclosure in a forensic setting.

Power

An aspect often critically discussed in the counselling and psychotherapy literature is the unequal division of power between therapist and client in therapeutic practice (e.g. Barker, Vossler & Langdridge, 2010; Howard, 1996). It is the therapist who has the power to dictate the therapy setting and ground-rules. While they reveal hardly anything about themselves in the session, the client is expected to lay open sensitive thoughts and feelings in front of the therapist in a situation when they are particularly vulnerable (McLeod, 2003). Together with the expert knowledge and language used by practitioners, this creates a power imbalance between therapist and client – something that has the potential to disempower clients as it 'may mystify problems so that clients become dependent on therapists and lose trust in their own abilities' (Barker et al., 2010, p. 340).

How the power imbalance might impact on therapeutic practice depends on the therapist's awareness of the risk of dependency of vulnerable clients in the therapeutic relationship, and how the therapy is delivered. It is part of therapist's responsibility to respect their client's autonomy and strive to support clients' control over their lives (Bond, 2010). Brief therapy approaches have shown that it doesn't necessarily need long therapy processes to help and empower clients in difficult situations, and a therapist can encourage their clients to use self-help material and community support in their everyday life at home. Clients have generally more control over what they want to disclose and the course of each session if the therapy is delivered online or over the telephone. The fact that they are not in the same room with the therapist can make it easier for them to express criticism or opt out of the session if they don't feel understood (Vossler, 2010a).

In a forensic setting, the power differential between therapist and client is more visible and heightened in the awareness of both therapists and clients. For example, in a secure or prison setting, therapists can be associated with the prison regime as they move around freely in the prison and carry keys to lock and unlock the doors – which is in stark contrast to their clients, whose movements are restricted and who can only get access to therapy through prison officers (Harvey & Smedley, 2010). Therapists might be seen as powerful figures that play

an important role for prisoners' chances and opportunities within the prison environment and beyond. All these factors will impact on the therapeutic relationship, and power imbalances in forensic settings can in some cases lead to boundary breaches and inappropriate relationships. Developing an awareness of these specific power issues and the feelings and attitudes towards clients is therefore a vital skill for a therapist working in these settings.

Some of the challenges of working therapeutically in a forensic setting that we have discussed in this section are interlinked in a recursive way. For example, a risk-dominated forensic practice can hamper the disclosure of sensitive material in therapy, and the lack of relevant information can make it more difficult for therapists to develop risk management strategies to support their client.

You will also see that these themes and challenges are running through this book and will surface in many of the following chapters, particularly in the chapters of Part III ('Sex and sexuality in mental health and crime') and Part IV ('Treatment').

Conclusion

This chapter has focused on the issues and challenges of working therapeutically in forensic settings. The aims of practitioners working in a therapeutic setting are to help individuals with life problems, while in forensic settings the aims are to manage risk and protect society. The differences between mental health and criminal justice systems are further accentuated by the fact that 'each system ... is underpinned by different funding streams, governed by different legislation and reporting to different governmental departments' (Rogers, Harvey, Law & Taylor, 2015, p. 6).

The differing aims of therapeutic and forensic settings underpin the systemic problems and challenges of working therapeutically in forensic settings. The need to simultaneously focus on the micro (helping clients with their specific needs, and managing risk to the client and practitioner themselves) and the macro (managing risk to others within the forensic setting, and to society) are at the heart of the challenges that forensic practitioners face. It could be argued that in forensic settings increased concern with risk and security, and greater power differences between practitioner and client coupled with the greater potential risk to clients regarding self-disclosure and potentially limited ability to give true consent, may make it less possible for *both practitioners and offenders* to engage willingly and fully with therapy. While this argument – that the forensic setting can be viewed as principally counter-therapeutic – can be usefully debated, it should not always be

seen as an inevitable consequence of working in forensic settings. As will be shown in this book, there is much evidence that despite the recursive interlinking of these issues, there is much that can be achieved with therapy in forensic settings.

Suggestions for further reading

Harvey, J. & Smedley, K. (Eds.) (2010). *Psychological therapy in prisons and other secure settings*. Abingdon: Willan.

This book introduces a range of therapeutic approaches used in forensic settings and discusses the specific challenges of this kind of work.

Rogers, A., Harvey, J., & Law, H. (Eds.) (2015). *Young people in forensic mental health settings: psychological thinking and practice*. Basingstoke: Palgrave Macmillan.

A very useful book providing an up-to-date overview of psychologically informed services and mental health provision in the UK for young people who display high-risk behaviours.