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**Social Supervision, Ethics and Risk: An Evaluation of How Ethical Frameworks
Might Be Applied within the Social Supervision Process – Jeremy Dixon**

Abstract

Service users subject to s. 41 of the Mental Health Act 1983 come under the scrutiny of both the mental health and the criminal justice systems. Much of the sociological literature in this area focuses on the growth of risk related practices where risk management is arguably displacing more traditional notions of care. Social workers who are working with service users subject to s. 41 are faced with a number of ethical dilemmas. This paper outlines Kantian, utilitarian and virtue ethics and their possible application to work with service users subject to s. 41. The ethical dilemmas in applying risk assessment tools are then examined. Finally, the article draws on published research of service user views in order to consider ethical dilemmas further. The author concludes by considering how social workers might apply the ethical principles discussed.

Key Words

Risk, ethics, mental health, social supervision, supervised discharge, mentally
disordered offenders, social work.

Introduction

Service users who are subject to s. 41 of the Mental Health Act 1983 (MHA) are subject to restrictions imposed by the Ministry of Justice on the grounds that it is, 'necessary for the protection of the public from serious harm' (quoted in Jones, 2008, p.234). This article argues that whilst concern for the protection of the public is not a new concept within forensic mental health, the way in which risk is understood has changed and that this has altered the way in which this service user group is managed. The article outlines how sociological views about risk have been applied to both mental health and criminal justice and considers what effect this might have on mentally disordered offenders. The emphasis on risk in legislation, policy and guidance is then examined. It is argued that social workers face competing demands and that ethical frameworks should be applied in order to consider right action. Kantian, utilitarian and virtue ethics are then explored and consideration is given as to how social workers can apply such constructs to current risk management practices. Finally, literature focussing on the views of service users subject to s. 41 is explored in relation to their understanding of risk. The author concludes that a utilitarian position is justified in work with this group of service users but that this position needs to be applied cautiously. Social workers need to balance a utilitarian framework against an awareness of service user autonomy. It is argued that risk assessment tools should be utilised but that social workers should use such tools in conjunction with their professional judgement.

The legal context

An order under section 37 MHA is made by a judge on the evidence of two doctors. In order to do this, the court should be satisfied that hospital treatment is the most appropriate means of disposal. In cases where a person is detained under s. 37 only, the clinician with responsibility for their case has the power to discharge the service user. However, the court may also impose a 'restriction order' under s. 41 of the MHA in cases where it is of the opinion that detention in hospital is (Jones, 2008, p.234):

‘necessary for the protection of the public from serious harm’.

The order places the responsibility for discharge from hospital, transfers between hospitals, and leave, onto the Secretary of State. The only other body with power to discharge a service user under a restriction order is the Mental Health Review Tribunal. The Ministry of Justice or a Mental Health Review Tribunal may choose to discharge service users, subject to the conditions of s. 42 of the MHA. Conditions may vary, but they will typically require service users to reside at a specified place of residence, to attend out-patient appointments and take prescribed medication and to meet on a regular basis with their social supervisor. The social supervisor has the role of facilitating the service user's return to the community, but also has a supervisory role. The social supervisor is required to report on a regular basis to the Ministry of Justice, giving regular updates on the service user's progress. If a service user fails to meet their conditions, the Secretary of State has the power to recall them back to hospital

The current legal and policy frameworks result in mentally disordered offenders being subject to two powerful social censures: that of being mentally ill and also deviant via

à vis society's laws (Duff and Garland, 1995). In doing so, they come to be defined by two of modern society's most powerful professions: medicine and the law (Webb, 1999). Service users subject to s. 37 / 41 of the MHA are dealt with by both systems. Duff and Garland (1995) argue that mentally disordered offenders are primarily defined by society through their mental illness (how they are), rather than by their crime (what they have done). However, this does not seem to be supported by the case law, which takes an equivocal position. The nature of the restriction order was considered by the Court of Appeal in R v. Birch (1989) 11 Cr.App.R.(S.) 202 (quoted in Jones, 2008). The court made the point that a restriction order merely qualifies a hospital order and was not a mode of punishment. The ruling goes on to say that (p.235):

‘no longer is the offender regarded simply as a patient whose interests are paramount’.

This creates an unusual position. The person who is sentenced is handed over to the clinicians who may diagnose and treat them. The seriousness of the crime allows the law to curtail the powers of discharge that a responsible clinician would normally hold in the interest of public protection. Consequently, service users subject to s. 37 / 41 are defined by both their mental disorder and their crime.

The MHA states that s. 41 is imposed for the protection of the public, whilst case law positions the service user as both a patient to be treated and as an offender to be managed. The Ministry of Justice guidance to social supervisors concentrates on the management of the offender and places the offender's need for care as secondary to this. Suggestions about the method of supervision are linked through the themes of risk and dangerousness. The guidelines state that (2007, para 28):

‘It is the Secretary of State’s hope that, by means of conditional discharge of a restricted patient, a situation of danger to the patient or to others can be averted through effective supervision, by appropriate support in the community or by recall to hospital if need be.’

The pre-occupation in the guidance with the management of risk echoes a pre-occupation with risk in modern society as a whole. The social nature of risk and how this relates to modern society will now be explored.

The pre-occupation with risk

Beck (1992) has famously argued that a pre-occupation with risk has become an intrinsic part of modern thinking. He writes that society has come to demand that risks be identified and controlled by appropriate bodies and that this occurs despite the fact that such bodies may have a limited capacity to do so. Douglas (1992) argues that this is because risk is not a ‘thing’ but a way of thinking. Similarly Loader and Sparks (2007) put forward the view that risk is never a dry technocratic matter, but rather is a political matter in which certain groups come to be viewed as the bearers of risk.

Public concern about risk from the mentally ill is not new. A number of societies have associated ‘madness’ with violence (Pilgrim and Rogers, 1999).

Research by Philo *et al.* (1996) showed that media coverage of mental illness highlighted violence to others in 66% of cases. However, the prevalence of violence suggested by such coverage does not reflect the levels of violence recorded. Dunn (1999) points out that Ministry of Justice criminal statistics show little fluctuation in

the numbers of people with a mental health diagnosis committing homicide between the periods of 1957 and 1995. In addition to this, the U.K. Audit Commission reported that there had been no increase in homicides by people with mental health problems between 1973 and 1993 (quoted in Flory and Darton, 2002). However, as Barham (1997, p.167) has noted, whilst community care has been carried out with a measure of public sympathy:

‘former mental patients are still under suspicion’.

The public view towards the mentally ill acquires an extra level of complexity when offending is involved. Risk theorists have argued that society has become more concerned with the distribution of risks than with the distribution of wealth (Beck, 1992). As a result of this, risk has replaced need as the principle around which health and social care services are organised (Kemshall, 2002). Consequently public perceptions about which populations pose the greatest risks become important. Webb (1999, p.158-159) has written that:

‘society is especially fearful of offenders who doubly transgress: those who are not only law breakers, but who in their mental deviancy are outside the domains of rational cognition’.

This fear is mirrored in both the criminal justice system and the mental health system which have been increasingly influenced by risk assessment and management procedures (Loader and Sparks, 2007; Peay, 2007). One reason for this is that the probabilistic models contained within the new risk management techniques appear to offer a greater degree of certainty than traditional models (Loader and Sparks, 2007). However, as Feeley and Simon (1992) have argued, such approaches have fundamentally changed the character of the criminal justice system. This change has brought about a ‘new penology’ which :

‘is neither about punishing nor rehabilitating individuals. It is about identifying and managing unruly groups’ (p. 368).

Modern society has developed a defensive attitude to risk in which the overarching aim is to be ‘safe rather than sorry’ (Kemshall, 2002, p. 9). As Peay (2007) has argued this risk-dominated approach within penology has infiltrated mental health policy. Whilst previous policies adopted a broadly treatment-based approach, these are now being overridden by risk concerns. This has led to a fusion between mental health and criminal justice objectives, with professionals being expected to engage in the potentially competing task of reformation and risk management with ‘the latter taking precedence where the former is in peril’ (p.501).

The notion that mentally disordered offenders may pose a risk towards others is, of course, not new. What has changed is the system of assessing and managing such risks. Assessment of mentally disordered offenders had previously been the domain of forensic psychiatrists who would make judgements on ‘dangerousness’ (2002).

Rose argues that dangerousness was seen to be an internal quality of a few pathological individuals but that in the 1970s and 1980s this understanding mutated and became, ‘a matter of factors, of situations, of statistical probabilities’ (Rose, 2002, p. 210).

Rose has argued that the growth of community psychiatry has, in turn, changed the character of forensic psychiatry. He writes that whilst the rule of law is still applicable to offenders, a parallel concern has developed in which issues of the rights

of victims and the general public are also considered in the context of an increasing 'fear of crime'. The logical consequence of this is that there is an increased demand that preventative action be taken against mentally disordered offenders and other groups who are seen to pose such a threat.

The policy position

Notions of risk management have gained an increasing profile in mental health policy generally. The Care Programme Approach (CPA) was introduced in 1991 in order to assess and provide for the needs of service users (Department of Health, 1990).

However, what was significant was that the assessment of risk was highlighted as an integral part of that approach. 'Audit packs' were issued in 1996 and identified three tiers of CPA with risk as the key organising principle (Fennel and Yeates, 2002). The National Service Framework for Mental Health (Department of Health, 1999) re-emphasised the Government's commitment to CPA. The Government's vision for mental health was summarised as being to provide services which were (p. 8) 'safe, sound and supportive' with the definition of safety being:

'to protect the public and provide effective care for those with mental illness at the time they need it'.

Notably, notions of public safety preceded requirements for service users to receive effective care. In doing so the policy echoed concerns expressed in inquiries into mental health tragedies which highlighted the need for effective risk management strategies (Ritchie *et al.*, 1994; Blom-Cooper, 1996). Not all commentators have been uncritical of this direction of travel. Preston-Shoot (1999) and Munro (2004) argue that policy has become tragedy-led and that such inquiries have focussed on individual situations, ignoring the context in which decisions were made. They argue

that the narrow scope of inquiries ignores the complexities of policies and procedures, decision-making processes, the nature of risk, organisational cultures and contradictory societal expectations. Despite such criticisms, inquiries have continued to highlight risk minimisation as a central aim. Social workers providing care are faced with ethical dilemmas in deciding how to balance the competing demands of care and control. Whilst social work literature has traditionally struggled with this notion generally, there is a shortage of literature dealing with ethical practice in relation to service users subject to s. 41.

Social work ethics

Social workers working with service users subject to s. 41 will be required to consider their practice with reference to the Codes of Practice (General Social Care Council, 2002). In addition to this, they also have to deliver care which is in line with the requirements of the Care Programme Approach (Department of Health, 1999) and will also need to be mindful of Ministry of Justice Guidance (2007). It is often difficult for social workers to navigate their way through the competing demands of professional standards, government policy and guidance from interested agencies. In order to examine how they might proceed, it is useful to consider how these demands fit within an ethical framework. Whilst ethical frameworks do not provide solutions to problems they can be effectively utilised as a tool for considering the basis for right action.

Kantian ethics draw on the ideas of Immanuel Kant. Kant's theory postulates that individuals should act in the right way driven by a sense of moral duty. Furthermore it presumes that individuals are endowed with reason and as such are capable of making moral choices. Kant saw humans as having the ability to create normative ethics of behaviour in which unconditional sets of moral rules could be established. Crucially, Kant saw the pursuance of moral principles as an ethical duty. The application of this form of ethics holds that human beings should always follow certain principles such as telling the truth or keeping a promise regardless of the consequences of such actions. There are a number of difficulties in applying a Kantian system of ethics to service users subject to s. 41. Firstly, this group of people are judged by the legal system to be mentally disordered. As such they do not fit the Kantian model of individuals endowed with reason. Secondly, in deciding whether to

make an order under s. 41 the court is also bound to give consideration to their potential risk to the public (Fennel, 2007). In so doing the court deviates from Kantian principles in that the outcome for the individual is considered in light of the wider social consequence rather than solely on individual action.

Utilitarianism ethics act in contrast to the Kantian focus on individual action. Within this theory action is seen as morally good if it produces the best possible outcomes for society as a whole. Guttman (2006) argues that two versions of utilitarian theory exist. The first of these posits that an act is correct if it achieves the best results and that this judgement is made irrespective of existing social laws. The second version of the theory places the social law as the criterion by which right action is determined. Within this framework the good of society is considered in contrast to the happiness of the individual who makes that action. Service users who are made subject to s. 41 are placed firmly within the second version of this utilitarian framework as they are restricted by social laws. In making a restriction order, the court is considering utilitarian notions of public protection rather than placing the basis for its judgement solely on the actions of the individual. In terms of discharge, a Mental Health Review Tribunal must order the release of a service user who is not judged to be suffering from a mental disorder of a nature or degree warranting detention (Fennel, para 7.87). However, these judgements still come from a utilitarian position as the consideration of risk to self or others remains, provided that the service user is judged to be suffering from a mental disorder.

Writers on social work ethics have argued that virtue ethics may offer a better alternative to practice dilemmas than the principle-based theories outlined above.

Banks (2008) reviews these current developments and writes (p. 1243),

‘challenges have come from a revival of virtue ethics (focussing on qualities of character), the development of an ethics of care (focussing on caring relationships), communitarian ethics (focussing on community, responsibility and co-operation) and pluralist, discursive and postmodern or anti-theory approaches to ethics (eschewing single, foundational all-embracing theories.’

Virtue ethics can be seen to reflect the core values of social work in that they aim to take account of the social inequalities which are seen to underpin the difficulties of individuals (Banks, 2001; Clark, 2000). Webb (2006) argues that the adoption of virtue ethics should give social workers the scope to act on sociological and philosophical principles. He suggests that this framework allows a focus on social relations and is not rule bound and argues that social workers should act as ‘strong evaluators’ who are able to,

‘exercise an ethical sensibility and judgement that’s based on their ability to contrast and value the worth of things’ (p. 205).

Webb’s vision of social workers as strong evaluators is an appealing one. However, current literature dealing with the application of virtue ethics to social work practice is still speculative in nature (Banks, 2008). In addition to this the application of virtue ethics also has certain problems when applied to service users subject to s. 41.

Webb’s vision of virtue ethics works in antithesis to a utilitarian position. He rejects social work practice based on the notion of risk and argues that practitioners should reject rule bound systems. As we have previously seen, current law and policy

encourage practitioners to minimise risk. Within this context social workers are faced with a number of risk assessment tools which claim to offer a means to risk reduction. This article will now consider these tools and question whether they can be applied in an ethical manner.

Ethical dilemmas in the use of risk assessments

Dolan and Doyle (2000) have identified three types of risk assessment within the current literature. The first of these is unaided risk assessments in which practitioners make a judgement on risk through clinical symptoms. The second type of risk assessment is actuarial methods which aim to provide assessment through measurement of a range of factors known to be associated with outcomes such as violence. The third model is structured clinical judgement which evaluates a range of statistically relevant factors but also allows flexibility for clinicians to make their own judgement.

Unaided risk assessments are the prevalent model in the UK (Walker, 2005). These assessments rely on the skill of a practitioner to identify risks and prescribe preventative measures. However, the accuracy of such practices has been challenged in research by Monahan (1984) that found that mental health professionals made erroneous predictions of violence in two thirds of cases. This has led to a push toward actuarial methods on the basis that quantitative research has demonstrated these to be the most effective measure (Bonta *et al.*, 1998). Canton (2005) argues that whilst such tools often claim to predict risk, they are better understood as probability statements. That is, the tools allow practitioners to calculate the probability that a person may commit a specific act through measuring specific traits. However,

whilst such tools may highlight high and low risk groups they also have certain disadvantages. Many of the identifiers of risk are static. That is they may group individual risk levels based on factors such as sex or age. In doing so, such tools often ignore individual factors (Walker, 2005) and also fail to deal with the residual majority of people in the middle-risk group (Home Office and DHSS, 1975; Prins, 1995). These limitations have led to the adoption of third generation risk assessments which aim to give due consideration to actuarial predictions whilst retaining professional decision making.

An extra layer of complexity is created when applying risk assessment tools to mentally disordered offenders. Research into whether the consideration of mental health factors provides any useful part in predicting recidivism amongst mentally disordered offenders is inconclusive. Research by Monahan (1984) and Bonta *et al.* (1998) has found that the best predictors of violence amongst mentally disordered offenders are the same factors for non-mentally disordered offenders. More recent research suggests that there may be a link between particular types of mental disorder and violent offending (Hodgkins, 2004). However, as Moore (1996) points out mental disorder may have both an inhibiting or disinhibiting effect and the impact of the mental disorder on individual behaviour can only be assessed through consideration of the individual.

Whilst discussions as to the use of risk assessments largely focus on their accuracy there is an ethical element to these debates. Advocates of actuarial assessments argue that this approach should always be preferred to professional judgements or a combination of approaches (Bonta, 2002; Grove and Meehl, 1996). Grove and Meehl

argue that to make decisions on professional judgement alone would be unethical. Their justification rests on the premise that professional judgement is unscientific and is therefore a poor use of public resources. They also cite potential victims of offences and suggest that their needs can only be addressed through taking a preventive approach based on actuarial evidence. . However, there are a number of problems with this line of argument. Even if the process of risk assessment is accepted as scientific then a number of false positives are likely to occur. As we have seen risk assessments do not predict risks but offer statements of probability. This leaves the practitioner with the dilemma about how to act on this information. Even if a risk assessment tool were to predict accuracy to a high degree this would lead to a substantial number of people being deprived of their liberty. Whilst actuarial assessments may be seen to have a higher degree of accuracy than professional judgement they still have a significant scope for error, a point which is acknowledged by some of their advocates (Bonta, 2002). Another argument against the use of actuarial approaches is that their claim to scientific validity is flawed. Webb (2005) argues that risk assessments are based on normative presumptions about society and that focussing on probabilistic mechanisms diminishes understanding. This argument reflects a concern for the potential for such tools to discriminate against certain groups such as minority ethnic groups.

So, how might social workers approach service users subject to a s. 41 in an ethical manner? As we have seen, policy and practice documents push practice towards a utilitarian framework. Webb (2005) argues that social workers should reject this framework on the grounds that it imposes a narrow and potentially discriminatory framework on its subjects. However, it should not be forgotten that service users

subject to s. 41 have committed serious offences against members of the public. Therefore a utilitarian position cannot be completely rejected. Whilst Webb's vision of social workers as strong evaluators is to be welcomed his analysis fails to acknowledge that there may be justifiable grounds to assess risk in order to aid public protection. Social workers need to be informed about the circumstances of the people with which they work. This should involve an assessment of an individual's social networks and value systems but should not lead to a wholesale rejection of risk assessment tools. Social workers should use actuarial assessments whilst remaining aware of their limitations. Actuarial assessments should never be used as the only means to decide a course of action. Professional judgement is needed in order to take into account the values embedded within the assessment tools. It is also necessary to take into account individual difference and social factors.

In using risk assessments social workers are demonstrating that they do not wholly reject a utilitarian stance. However, the difficulty with adopting such a position is in making a judgement as to where risk taking can be justified. The current climate of intolerance for risk taking in general tends to discourage this. As Rose argues (2002) there is a tendency for all untoward incidences to be seen as a result of failure in professional judgement. This has led to risk averse behaviour within social work in which workers may minimise risk in order to aid defensibility (Carson, 2000). This dilemma might be resolved through consideration of the Kantian position in which individuals are seen as being endowed with reason. Whilst service users subject to s. 41 are likely to have been mentally disordered at the time of their offence they may go on to regain autonomy. One of the problems within the forensic mental health system is that the autonomy of the individual is not often re-evaluated with a view to

returning their legal rights. In addition to this, the risks that service users may pose whilst mentally disordered or in a normal state of mind are often conflated. For example, the restriction order is seen by the Ministry of Justice to be an effective form of risk management because re-offending rates are rated as low (Fennel, 2007).

However, these figures do not take account of the autonomy of the service user who does re-offend. If social workers are to act in an ethical manner then decision the actions of service users needs to be considered in the light of their level of autonomy.

The skill that social workers must develop is the ability to work within a framework which considers risk, whilst at the same time not losing sight of the needs of the individual. In doing so, they should accept the need to apply a utilitarian position which considers public protection whilst regularly re-evaluating the appropriateness of this position through consideration of service user autonomy. In seeking to apply an appropriate balance practitioners should be aware of the limited research into service user views in this area.

User views about social supervision

There are currently five studies examining the views of those subject to conditional discharge (Dell and Grounds, 1995; Godin and Daves, 2006 Riordan *et al.*, 2002; Davies *et al.*, 2008; Coffey, 2008). Davies *et al.* (2008) carried out a four year qualitative study into an English Medium Secure Unit. A notable aspect of this study is service users' awareness of the way that staff categorise risk and the ways that they adapt their behaviour in response to this. Davies *et al.* focus particularly on the

environment of the medium secure unit and the difficulties of accurately assessing risk within it. They write:

‘Forensic mental health care is beset with inherent problems, ironies and deceptions (bluff and double bluff)’ (p. 87).

They argue that in order to be released service users need to convince professionals that their ‘high risk’ status is no longer valid. Professionals carry out assessments of risk in an environment that does not mirror that of the community. Risk is measured through constant observation which is located in clinical notes. These notes are then interpreted in clinical meetings, often without the author present. Service users are aware of this process and learn to reflect on how their behaviour is interpreted. In order to provide a credible narrative that will convince staff that their risk has reduced service users learn to second guess staff intentions. This theme is echoed in research by Godin and Davies (2006) into the views of service users who had been subject to secure provisions. Participants commonly stated that they had to ‘play the game’ (p.44). One service user characterised this as agreeing unconditionally with his doctor’s view of him and spoke of the difficulty of acquiescing to a new ideology when his doctor changed. Coffey’s research (2008) also found that service users acquiesced to professional views in order to achieve discharge. He notes that service users often felt compelled to accept conditions proposed at their Mental Health Review Tribunal but that their perspective on these conditions varied once they had achieved discharge.

Once service users are discharged from hospital they experience a new set of challenges. Research by Dell and Grounds (1995) and Riordan *et al.* (2002) focussed on the positive and negative things about supervision from the service users’ point of

view and there is substantial overlap in these findings. The process of supervision was largely valued by participants who found the support that they received to re-enter the community useful. In addition to this they valued the guarantee of longer term practical support from a social supervisor. They also felt that the framework provided a guarantee that they would receive psychiatric treatment in the future.

Participants expressed negative feelings towards coercive aspects of supervision and felt that it disallowed them personal autonomy and privacy. Participants in the study by Dell and Grounds (1995) spoke of the threat of recall to hospital being a constant worry and complained of the arbitrary nature of such decisions. In addition to this, they disliked attending meetings at the hospital in which they had been detained.

Riordan *et al.* (2002) reported that some participants felt that being compelled to have injections of psychiatric medication was the worse aspect of supervision.

Participants in the Dell and Grounds (1995) study made passing references to risk.

The majority felt that it was right that they should be subject to supervision on discharge. This view appears to be based on the practical support that was provided, although participants also acknowledged that its purpose was to protect the public from serious harm. Dell and Grounds report that participants generally agreed with this purpose, although some felt that the supervision should be tapered off over time.

In order to achieve discharge, service users have to negotiate a series of procedures with the concept of risk at their heart. Despite this the research suggests that service users do not react in a wholly negative way towards social supervision. The forensic mental health system is utilitarian in nature and its input into the lives of users can be experienced as double edged. Thus whilst s. 41 is intended to limit risk, the process

itself guarantees a certain level of service provision which is at least in part experienced as supportive. However, the presumption of limited autonomy which goes hand in hand with this framework can result in service users' views not being heard. In addition to this, the mechanism of social supervision is not experienced by service users to be responsive towards their increasing independence and as such takes little account of autonomy. The accounts by service users also highlight that their own understanding of risk is an important but neglected part of the equation. Service users do not wholly reject the notion that they have posed a risk and that protective measures may therefore be warranted. However, service users' understanding of the concept of risk is currently under theorised (Davies *et al.*, 2008) and future research should aim to develop a more sophisticated understanding of this

Conclusion

Service users subject to s. 41 of the MHA are defined both by their mental disorder and their offence(s). Whilst they have always been subject to supervision, under current mental health legislation, the societal attitude to risk has altered, in turn changing the kind of supervision that they experience. Mental health policy has become increasingly pre-occupied with the concept of risk and now holds risk as one of the key principles around which services should be organised. Forensic mental health care has also shifted its emphasis from a focus on dangerous individuals to a wider model that focuses on risk prevention.

This paper has considered how three ethical frameworks might be used to support social work practice. In considering whether or not to place an individual under a restriction order a court must be satisfied that they are suffering from a mental

disorder. This places them outside a Kantian frame of ethics which presumes that individuals are endowed with reason. Service users subject to s. 41 MHA are subject to a utilitarian frame of ethics in that they are subject to restrictions on their liberty and that the motive for these restrictions is for the good of society. The current trend towards risk prevention makes service users subject to risk assessment procedures. These procedures claim to provide a greater degree of accuracy in risk prediction but actually provide practitioners with a probability statement rather than a means to prevent risk. Advocates of virtue ethics have argued that social workers should reject such tools on the grounds that they are based on normative social presumptions which do not take adequate account of social difference. However, such a position tends to minimise the validity of public protection. Service users subject to s. 41 have committed serious offences and a degree of risk management is therefore justified. Social workers should not therefore completely reject a utilitarian approach. In making judgements about risk it is legitimate for social workers to consider information from actuarial sources but these tools should never be used as the sole mechanism for decision making. Social workers should take such information into account in light of social and individual factors and with an eye to the normative standards implicit in such assessments. They should be aware of the particular environmental challenges that service users subject to s. 41 face moving between legal, hospital and community settings. The way that service users conceptualise risk is little understood and future research in this area may improve social work interactions. Finally, the adoption of a utilitarian approach poses the problem of when risk assessment should be discontinued. In considering this problem social workers should return to the Kantian framework and give regular consideration to the service users' ability to reason autonomously.

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