Managing madness, murderers and paedophiles: Understanding change in the field of English forensic psychiatry.

Abstract

This paper discusses changes occurring in the field of English forensic psychiatry which appear to be linked to feelings of discomfort amongst medical professionals who manage care in such settings. These changes are neither the result of a sudden 'shock' to the system, nor small improvisations at the margins, but instead appear to reflect a growing perception amongst psychiatrists of accepted field practice as inadequate for some types of patients. To understand how feelings and emotions are implicated in these changes we draw on and develop the work of Pierre Bourdieu to suggest that changes must be seen in the context of field tensions, which have implications for habitus. However, we do not view feelings of discomfort merely as a response to these tensions. Instead we suggest a more dynamic process with the habitus playing a key role in structuring what people pay attention to and how they perceive it, as well as whether they experience particular feelings in the first place, therefore.

Introduction

In the context of a healthcare field characterised by struggle and hierarchy, a growing number of scholars have drawn on Pierre Bourdieu's work to help understand professional behaviour change (e.g. McDonald 2009). For the most part, this literature does not engage with issues of feelings and emotions and where it does, it tends to focus on fear and anxiety in the context of top down reforms which throw habitus out of alignment with the field (e.g. Kirschner and Lachicotte 2001). This relative neglect of emotions is understandable given that Bourdieu rarely addressed emotions explicitly as a category of analysis (Scheer 2012). Yet Bourdieu's writings, which emphasise embodied practice in a context of an interplay between social structures and agency provide a potentially powerful lens through which to explore this issue (Zembylas 2007).

Using Bourdieu's work to explore emotion requires an understanding of his concept of habitus, which is an embodied collection of rules, norms, codes and dispositions that structure an individual's interactions with the social world. Individuals acquire dispositions 'through experience, varying from place to place and time to time. This 'feel for the game' . . . enables an infinite number of moves to be made, adapted to the infinite number of possible situations which no rule, however complex, can foresee' (1990a: 19). Action is seen as pre-reflective and embodied, with players making choices which, while not deliberate, are nonetheless systematic (Bourdieu 1990a). Emotion is part of this embodied knowledge. 'The body believes in what it plays at: it weeps if it mimes grief. It does not represent what it performs, it does not memorize the past, it *enacts* the past, bringing it back to life'. What is "learned by the body" is not something that one has, like knowledge that can be brandished, but something that one is' (Bourdieu 1990b: 73). According to Probyn, Bourdieu distinguishes between a feeling body and emotion with the latter a 'cognitive adjustment mechanism' (2004: 232). This has some parallels with sociocultural approaches to emotion which

distinguish it from affect. Affect involves embodied sensations and these are made sense of in the context of cultural categories that we think of as emotions (Leavitt, 1996, pp. 524–525). Probyn describes the habitus as sorting out confusion relating to what bodies feel and reproducing 'the feeling of inevitability' (Probyn 2004:232) which helps maintain and reproduce the status quo. This inevitability ('it *enacts* the past') is seen by critics as closing off opportunities for change (Wetherell 2012).

Bourdieu's work has been described as being better able to explain continuity and reproduction than change (Crossley 2001), although Bourdieu stresses that habitus involves change as well as reproduction. His account of change encompasses small changes at the margins which result in changes in the field over a long period of time. Alternatively, change may occur when the habitus is out of alignment with the field as a result of sudden shocks to the system (Bourdieu 2000). Whilst Bourdieu stresses that the habitus is never wholly determined by field structures, his work raises questions about how and why actors initiate change. According to Probyn there might be times when 'feeling shakes up the habitus; when the body outruns the cognitive capture of the habitus' (232). Probyn describes the impact of affect in jolting individuals into action in a way that disrupts the habitus. To some extent, the idea of jolting people into action has parallels with Bourdieu's view of sudden change, with the habitus being out of alignment with the field. This raises questions about processes which do not involve sudden change and how emotions might be implicated in those. We explore this question using data from a study examining changes in the field of forensic psychiatry, which appear to be linked to feelings of discomfort amongst medical professionals who manage care in such settings.

Study Context

In English secure forensic psychiatric settings patients are viewed as a risk to themselves and others and needing to be contained therefore. Since patients may lack capacity, it may be necessary to coerce them into complying with treatment regimes and practices. From the perception of the public, these patients, many of whom are murderers, paedophiles and rapists, are dangerous and evil (Pilgrim 2007a). There is some evidence that these attitudes resonate with some members of staff and these hospitals in England have at various times been the subject of public inquiries and calls for their closure (Pilgrim 2007a). A 'recovery' (Shepherd et al. 2008) based approach to rehabilitation, in contrast to the traditional medical models of treating people with severe mental illness, aims to empower patients. The problems of these 'total institutions' (Goffman 1961) were highlighted in inquiries in the 1980s which found that the emphasis was on producing places of incarceration with staff engaged in excessive brutality, routine seclusion of newly admitted patients, 'inflexible and over structured regimes…. and too little scope for the development by patients of self-awareness and self-control' (Martin 1984: 55).

The Ritchie Report (Ritchie et al. 1994), following the fatal stabbing of a passer-by by Christopher Clunis, a patient with paranoid schizophrenia, identified numerous system failings. Such incidents contributed to a policy of providing additional resources for forensic psychiatry, with the numbers of forensic psychiatrists recruited rising steadily since the mid-1990s. Although changes have been made following successive inquiries in the 1980s and 1990s, hospitals in England tend to have more restrictive regimes than their counterparts in other countries (Salize and Dressing 2005). At the same time the NHS Plan (Department of Health 2000), in recognition that high secure hospitals were not always the most appropriate place for patients, set a target for discharging around 400 people to medium secure facilities. This resulted in an 'Accelerated Discharge Programme' (ADP) which involved staff in reviewing patient populations to meet this target.

The State's emphasis on active treatment and rehabilitation and a move away from institutionalisation also helped to fuel the growth of forensic psychiatry as a profession. It has grown from '2 professors and 18 consultants confined to working in a few grim special hospitals' (Turner and Salter 2008) in 1970 to around 260 consultant doctors according to the latest census (Centre for Workforce Intelligence 2010). In terms of what is in patients' best interest, the Royal College of Psychiatrists (RCP) has stated that the only reason for psychiatric intervention is for patient health benefit, with any related public protection function being secondary to this (Coid & Maden 2003). An emphasis on applying treatment to deliver health gain means that even for conditions such as 'personality disorder' which were until the end of the last century in the UK generally agreed to have no effective treatment, some psychiatrists have argued to the contrary (Pickersgill 2012; Manning 2002). The inclusion of personality disorder in the 1959 Mental Health Act was controversial and has been interpreted as enabling social regulation (Manning 2002). What constitutes personality disorder has been the subject of disagreement and debate (Pilgrim 2001) with some suggesting that the concept should be abandoned (Lewis and Appleby 1988).

In the Netherlands forensic patients for whom effective treatment does not exist and are therefore deemed to require lifelong care reside in a facility located many miles away from the secure hospitals (Uslu and Mok 2009). They are not subject to medically intensive psychiatric treatment or psychological interventions intended to reduce their risk but are likely to enjoy a superior quality of life to those in secure hospital settings. No such facilities exist in the UK, but the State has been preoccupied for many years with the question of how to lawfully control mental disorders, or at least those aspects of behaviours amongst the mentally disordered which pose a threat to the social order (Pilgrim 2007b; Pilgrim 2001). A new phrase of Dangerous and Severe Personality Disorder (DSPD) was introduced in 1999 by the British Home Secretary. New powers were proposed to enable individuals classified as

having DSPD to be subject to indeterminate detention. These can be seen as attempting to assert control over clinicians, by requiring them to contain individuals as part of a process of social control (Pilgrim 2007b) and they prompted a backlash from some sections of the forensic psychiatry community (Pickersgill 2012). They can also be seen as requiring psychiatrists to take charge of individuals for whom they can provide no effective treatment.

That same year, the Richardson Report (Department of Health 1999) which contained advice to government on how to proceed with new mental health legislation, emphasised the need to balance compulsion with patient entitlement, which places obligations on those organisations providing care. It proposed extending the treatability test, which required that detention in hospital of people deemed to be a risk to themselves or others was only legal if their condition could be treated. However, the 2007 Mental Health Act abolished the 'treatability test' and merely required hospitals to ensure that 'appropriate treatment' was available, with no requirement for the treatment to be effective. As the foregoing illustrates, the field of forensic mental health can be characterised as involving struggles and competing views in relation to its purpose and the methods by which these should be achieved. Drawing on Bourdieu, struggles within fields are only to be expected, as we elaborate in what follows.

Bourdieu, field, capital and affect

For Bourdieu all social action takes place within a field, which is a site of struggle for legitimation. Different actors with different stakes in the field are engaged in an ongoing process of contest in relation to the dominant field norms and institutions. Bourdieu likens this to a game, in which individuals pursue interests. The notion of interest is concerned with being invested in the game and individuals are socialised strategic game players. For Bourdieu 'Interest is to "be there" to participate in the game, to admit that the game is worth playing…Between agents and the social world there is a relationship of infraconscious,

infralinguistic complicity' (1998:79). Fields are characterised by hierarchy, so not all actors are equally well placed in terms of their ability to accumulate resources and prestige within the field. Capital (economic; cultural; social e.g. networks; and symbolic, referring to status or recognition) is distributed throughout society and has an exchange value within the field. For example, forensic psychiatrists are likely to be well endowed with cultural capital, which concerns forms of knowledge, skills and education. Psychiatrists are likely to be relatively powerful players in the field of forensic mental health therefore. Although the State's ability to introduce changes despite opposition from psychiatrists demonstrates that there are limits to their power.

Individuals are 'bound to social fields by a strong affective grip. The rules and stakes of a specific field might seem worthless and arbitrary to an outsider but players feel their 'weight' with great emotional intensity' (Crossley 2001: 102). Habitus and field help constitute each other. 'On one side…the field structures the habitus…On the other side, it is a relation of knowledge or cognitive construction. Habitus contributes to constituting the field as a meaningful world, a world endowed with sense and value, in which it is worth investing one's energy. (Bourdieu and Wacquant 1992: 127). This is a temporal process whereby the tendencies of the field are incorporated into the body and lived as taken for granted physical and emotional dispositions. At the same time, this is an interpretive and active process rather than merely one of repetition (McNay 2000, 38). Bourdieu describes how in relations of domination, agents experience 'internal conflict' involving 'experiencing the insidious complicity that a body slipping from the control of consciousness and will maintains with the censures inherent in the social structures'(2001: 39). Dispositions to act in certain ways 'a social law converted into an embodied law' (Bourdieu 2001: 39) cannot be suspended easily. Dispositions have an enduring effect which operates at a pre-conscious level. At the same time 'Legitimization of the social order is not the product …of a deliberately biased action of

propaganda or symbolic imposition; it results from the fact that agents apply to the objective structures of the social world structures of perception and appreciation that have emerged from these objective structures' (Bourdieu 1990a:135).

In the context of field struggles and the potential for field tensions to create feelings of unease, language plays an important role. Bourdieu's notion of symbolic power concerns the naming and classification of things in such a way as to structure social realities. Linguistic exchanges involve a degree of self-censorship. 'Discourses are always to some extent euphemisms…they are compromise formations…resulting from a transaction between the expressive interest (what is to be said) and the censorship inherent in particular relations of linguistic production' (Bourdieu 1991:78-79). Such self-censorship is not the product of a consciously calculating set of 'rational' actors, but concerns habitus and its relation to the field in which it is operating. Increased tensions in the field will increase the degree of euphemisation which takes place and this process reflects the 'taken for granted' knowledge of the field on the part of speakers. Ways of speaking are not neutral, however, but serve particular interests.

Methods

The data on which this paper is based are drawn from a study involving interviews with 22 doctors (Consultant forensic psychiatrists - about 8% of the workforce nationally) and four commissioning managers who are involved in discussions about service contracts, as well as placements for individual patients. Doctors from 20 different facilities were interviewed as our aim was to understand the range of types of services provided and differences and similarities between facilities. We also interviewed legal experts (n=two) and three other people (a learning disability specialist, a policy lead from the Ministry of Justice, and a former manager with experience of the Accelerated Discharge Programme). The interviews

were conducted between 2013 and 2015. All interviews were digitally recorded and transcribed verbatim. Some were conducted on a face to face basis (n=four), but most were telephone interviews. Taking recording equipment into secure facilities requires applying for various permissions in advance and negotiating the different approval processes of each of the facilities. Many interviewees suggested that we conducted phone interviews with them to avoid them having to process paperwork on our behalf therefore. We used a mixture of purposive and snowball sampling to recruit participants across a broad geographical area. Initially we contacted psychiatrists who were members of an advisory group informing commissioning decisions because we wanted to speak to individuals who might have a broad, as well as local knowledge.

We also went to three 'long stay' secure forensic facilities where we visited wards and met and talked with staff and patients. For one of these visits we made notes as soon as we left the facility as we were not allowed to take in recording equipment. At the other two visits we held a focus group with staff (2 nurses, 2 psychiatrists and 1 psychologist) and digitally recorded these. We also held a focus group at a forensic psychiatry conference comprising 3 psychiatrists and 2 members of the research team. Our study was concerned with understanding current provision for 'long stay' patients, with a view to exploring whether or not this could be improved, since this is an area which is unexplored. We asked interviewees and focus group participants to describe services and we sought their views on alternatives to current service provision, such as the facilities in the Netherlands.

Initially a small number of the interviews were coded thematically using NVivo software. Emerging themes were discussed amongst team members and disagreements resolved and queries clarified. This process continued during data collection and was used to modify the interview topic guide to incorporate new areas of investigation as the study progressed. This also informed the focus group discussions and site visits. The latter were conducted towards

the end of the interview process. There was no prior intention to use a particular theoretical framework for data analysis, although after the initial analysis we revisited the data and we went beyond merely identifying themes to examine how the tensions in the field were negotiated. In addition to identifying common themes we also explored differences and reasons why these might occur. This meant analysing transcripts as whole documents in addition to merely synthesising disembodied sound bites grouped under thematic headings. All quotes used are from interviews with psychiatrists unless otherwise specified.

Findings

Change and stability in forensic psychiatry

Doctors' accounts conveyed a picture of a complex and changing field. Some described how the ADP, or state sponsored review of patients in all high secure hospitals (a shift towards recovery, as opposed to incarceration) many years ago had led to an emphasis on more active rehabilitation, rather than merely containment. One doctor referred to being shocked by staff inertia and attempting to change staff behaviour as part of his early experience *'getting high secure units to start wanting to help people….. "he's been here fifteen years and done sod-all with you and you're actually getting in the way of his life"'* (ID 10). Rather than relying on habitual, taken for granted behaviours, this doctor, as a new arrival, with no history of behaving like the staff he encountered, attempted to change practice, drawing on his training with its values of treatment, recovery and rehabilitation.

An emphasis on treatment was common to almost all accounts. This is understandable given the dispositions and related field norms which involved focusing on rehabilitation/recovery. Yet 'wanting to help people' implies that there is effective treatment. In general hospital settings, the growth of 'evidence based medicine' (EMB) has implications for the ways in which clinicians practise. It has been used to construct a large number of treatment

algorithms and guidelines which assist clinicians by providing advice on effective treatments. However, in forensic mental health settings, unlike in general hospitals where EBM may be appropriate for patients who have, for example, broken their hip, the evidence to guide practice may be much less clear. As one doctor described it, secure forensic psychiatry involves dealing *'with patients ....at the end of the distribution in terms of risk and complexity, algorithms don't work very well ....they tend to have broken the algorithm before they get here'*. (ID8). Furthermore, with patients who are treatment resistant, the 'admission, treatment, rehabilitation, cure' trajectory is not so readily applicable.

A focus on treatment can be interpreted as psychiatrists engaging in habitual behaviour which helps to preserve their status within the hierarchy. If doctors accept that there are patients for whom 'treatment' may be merely containment, then this raises questions about the role and value of doctors in these settings. Amongst many doctors there were objections to the idea that some patients should not receive treatment. The practice of medical professionalism dictates that doctors should use their judgment to decide what is in the best interests of the patient. In many cases, this meant continuing to treat patients, but it appeared at times to be regardless of whether this had an effect, so that treatment became an end in itself. It also meant that doctors acknowledged that some patients would never be released and talked about this with colleagues but at the same time appeared to maintain hope and a belief that such patients would change and eventually be able to leave. The quote below illustrates these tensions.

'I have one particular person who has either been in prison or medium secure for 27 years. However, that guy has an extremely severe personality disorder, extremely severe mental illness, he has committed one murder and two attempted murders and has actually an excellent quality of life... I personally do not see this as a problem…It becomes a problem if you are not able to offer appropriate treatment. We do offer appropriate treatment…. I think

even if someone's been there for twenty years you should still be trying to do something even if it's on a very sort of basic level ... you may not be doing actual psychological treatment but you could still be working with an occupational therapist ...looking at behaviours, communication skills or whatever it is .....we all pay lip service to the fact that we do .. every six months [a] review [for patients who are not going to move on] ....you can't just put a statement up, 'this person in long term medium secure'....I'll adjust the treatment as best as I can as I go and if they need to stay they need to stay...Everybody knows [this patient won't be going out] yes, well we even probably do talk about it, but you just have to keep reviewing their care ... and what was a hopeless situation a couple of years ago you can review that person and say well actually they have made some progress and maybe they could have a try out in low secure. (ID3).

Doctors' attitudes can also be interpreted in the context of a reaction to archaic practices which characterised the field in the past and left patients languishing on wards. This past was not just reproduced in the form of habitual behaviours, but challenged in a way that over time, has resulted in new field behaviours. Selective non-treatment or diminished treatment for a specific targeted group is very different from a more generalised form of clinical neglect. Yet changes in field practices, which acknowledge that some patients may be better off without further treatment take time to become accepted and taken for granted. In addition to doctors' attitudes which may prevent such changes, there are also other pressures to continue to treat patients who may not benefit from treatment.

Psychiatrists' views also reflect a need to maintain hope, for the patients, but also for themselves as working professionals. In terms of taken for granted behaviours and assumptions, being able to imagine that patients will move on appears to be important to staff working in these settings. This meant that many doctors appeared uncomfortable with the idea that there might be two distinct groups of patients, with one group likely to 'step down'

to a lower level of security in secure facilities and the other group likely to remain in hospital for most of their life. There was recognition by all doctors that some patients would take longer to progress through the system than others, but for some, this did not necessarily imply major distinctions between patients in terms of the care provided.

Not all doctors held the view that all patients would follow a treatment path aimed at achieving their discharge to a lower level of secure care and ultimately to the community, however. Some highlighted the deficiencies of the current approach which meant that the patients who may never leave *'are still on their recovery ward so the gamut of therapy, groups etc. would be the same'* despite the fact that *'it's long term care until physical health deteriorates and results in residential nursing home care…a thirty to forty-year job'* (ID11). Even where doctors acknowledged that there would be patients who would never be discharged, they often felt uncomfortable in explicitly discussing this with patients. Some interpreted field rules as not allowing such behaviours *'I sometimes want to say, "You know what? You've arrived and you're not on a journey now" and we're not allowed to say that. It is seen as unprofessional or lazy of giving up, where actually, it might be the most humane thing to say'.* (ID23 focus group).

Amongst commissioners there was a greater appetite for identifying patients who might never leave. This can be interpreted as reflecting a desire to save money, since the costs of secure hospital care are very high, but it might also suggest a recognition that existing provision is inappropriate in some cases.

'I was on one of the women's wards a couple of weeks ago and there's a woman there ….. *She needs a secure environment because she is treatment resistant, to use a technical term absolutely 'mad as a hatter', but doesn't need… the level of security that you have in high*

secure. ...there are people in the long term service who don't need it, but there's nowhere for them to go'. (ID13 commissioner)

Doctors described how the impetus for thinking about alternative forms of practice was not a sudden 'one off' external policy directive, but a growing perception that the needs of this group of patients were different in a way that had implications for care provision. Over time, this prompted some doctors to reflect on their habitual behaviours and to question their validity. Patients who had committed particular kinds of offences that made them targets within the hospital for other patients who would gain status by threatening or assaulting one of the higher profile patients meant thinking about *'collecting them together... keeping them safe and quality of life [being] ...important aspects of their humane care'* (ID5). Existing provision which involved mixing the two groups of patients had meant that those who did not progress might be unsettled by the high turnover, as well as being fearful of other potentially violent and disruptive patients. Having these two groups on one ward made it difficult to provide a context which was *'more homely than sterile'* (ID9).

Imagining alternatives

Not all psychiatrists were opposed to the idea that some patients would never leave secure care. Five respondents highlighted changes in the ways in which particular generations of psychiatrists were trained and the extent to which these impacted on their ability to contemplate alternative futures.

'...modern psychiatry... everybody who's trained in mental health, nurses and doctors, has not had access to that whole literature from the sixties about what goes on in institutions. So they're handicapped I think by not understanding that if you work in long stay residential care life is different, you know the way you talk about life and the way you organise your relationships, cure doesn't make much sense. But care makes a lot of sense but care is

complicated.… some people can still find some work and fulfilment in their life, even if they're detained for life in custody… it's never about just warehousing… But you're being honest and open with the person'. (ID17)

'So the climate of risk that contaminated forensic care sort of post-Clunis… in the nineties and enthusiasm of people coming into forensic psychiatry to go along with the government agenda ... So there's a kind of cohort of forensic psychiatrists who have been brought up and cut their clinical teeth during that period. And there are obviously a few old bats left! (laughs) who run crazy forensic services with community facilities... So you know people have different experience and they've been trained in different ways ...but I think that one has sometimes…got to recognise the gravity of what people have done and that psychiatric discourse is only one of many relating to that and that it doesn't necessarily determine what happens. So getting better doesn't necessarily mean leaving hospital'. (ID18)

As the above quote suggests, for some patients, the nature of their offences may mean that they can never be released, even though this is not explicitly acknowledged. With regard to provision for permanent residents, most doctors had some knowledge of the system operating in the Netherlands and their views on this were influential in the way they approached service change as the quote below, from a doctor who was involved in thinking about new services at the time of the interview, illustrates.

'For the people who are not going to get to the community ….I went over to Holland to look at their long stay process, what I couldn't really understand from them... How do you get back out of that? So we didn't want to have a model whereby people were put into that. We wanted a model where, yes you're being managed long stay but any stage if they wanted to engage with the sort of normal process…it's there, there's no barrier at all…. you're not going to put someone through say the illness awareness group for the third time. They're not

going to just keep doing it, at one point you say, this person's done this a couple of times,
stop. No point having one-to-one psychology ad nauseam. So there will be a shift from [that
to] long sort of chronic just quality of life stuff'. (ID15)

There was a range of responses from doctors when asked for their views on a system such as
the service in the Netherlands. One respondent suggested *'we learn from others, we actually*
pilot and develop a proof of concept model and just see what impact it actually has', although
that *'from a personal ethical perspective'* they would never say *'I don't think there's any*
chance of you being discharged' but would couch this in less threatening language such as
'"obviously you've been in hospital for x number of years, your discharge isn't around the
corner … maybe more opportunities for the kind of thing you're interested in such
as…whatever that is and that unit may be able to provide. Would they consider moving or
having a period of time there just to see how it goes?" I'd be more inclined to take that
approach'. (ID1)

Another was relatively supportive of such arrangements suggesting that it would be better
than existing provision with *'people who are in units that are not designed for treatment*
resistant individuals …and maintaining an absolutely hopeless degree of optimism… being
required to repeat ad infinitum appropriate interventions which are destined in no way to be
successful'. (ID2)

Most, however, expressed caution about adopting something based on the Dutch system. In
addition to the perception that stopping treatment in that way amounted to *'warehousing'*
(ID3), the fear was expressed that labelling patients as *'long stay'* would produce a particular
'mind-set' (ID6) amongst the staff, with *'a real risk of self-fulfilling prophecies'* (ID8). *'I*
don't really care what it's called.…I would be concerned about the mind-set'. (ID6) The
issue of 'what it's called' appeared to be important for many doctors, a point to which we
return later in our discussion of language.

Changing practice

In some cases, doctors reported having been involved in initiating changes in service provision and ward configuration to actively separate patients into two groups. This had implications for the care provided in each of these settings and suggested a different way of organising service provision for patients who were 'treatment resistant' and/or had no 'insight' into their condition despite having undergone various treatments and were likely to remain in the hospital for a very long time. Such settings were focused on improving quality of life and safety, rather than active medical treatment.

'Over time ...staff have taken a much more recovery and rehabilitative focus and people are moving through. They now sort of have two groups of patients. They have a group of patients who are ....moving and they still have a small cohort of patients who probably will be regarded as long stayers. It's difficult to see them moving on... lots of patient involvement. Free from things like bullying, intimidation, harassment, all that kind of obvious stuff ...'. (ID14)

'A larger focus on sort of, ward-based activities, community activities, maybe cooking or plan of the day meetings, current affairs groups etc. So a real sense of a community...They've got their own lounge area, TV, the rooms are probably a little bigger. It's got a different feel to the place'. (ID9)

To some extent the process of putting plans into practice was a response to everyday problems and emergent issues. In one case, a facility was established to take patients from a high secure hospital who were unlikely to be released into the community but who could be housed in a medium secure facility. In another example, a psychiatrist was aware of patients placed hundreds of miles from home, which made it difficult and expensive for their aging parents to visit. He described working with local commissioners and hospital staff, as well as

allaying the fears of the local community to develop a facility which would bring back patients located in various expensive placements far away from their families. This doctor and his team took the opportunity to visit other facilities in the planning stage to learn about and learn from what was happening elsewhere. He liaised with service commissioners and the local community from an early stage to increase support and legitimacy for the new development. In addition, the offer of being able to provide services more cheaply was attractive to commissioners. In other cases, existing patients were relocated within the existing facility to create a stable long stay environment in response to the needs of patients. Here it was necessary to negotiate with and gain agreement from commissioners that these wards would be exempt from length of stay targets in recognition of the nature of the patient population. In one site, commissioners colluded with a service provider to maintain the fiction that services were no different for this group of patients *'Commissioners do not commission long-stay medium security. They do really, because the people are having it, but they don't officially'* (ID3). Elsewhere, the explicit support from commissioners helped to lend legitimacy to such services.

Even amongst doctors who conceptualised 'long term' patients as a distinct group requiring a different approach from other patients, some reported barriers to change from external stakeholders. Despite the removal of the treatability test, various stakeholders did not view cessation of active treatment as legitimate.

'I think it depends where things go with level of care planning intervention etc., with CQC [a regulatory body] expecting patients to have full therapeutic programmes which may not be appropriate for certain long stay patients…. sometimes their solicitors, the tribunal expect you to be doing just as intensive work with somebody who's been in for fifteen years as has been in for one year. And I think A – that's unneeded and B – it's not realistic. So I think there probably needs to be a mind-set change there' (ID12)

Whilst some doctors were very resistant to segregating patients in this way, even amongst those who acted to reconfigure services there appeared to be some discomfort with regard to the nature of service provision for such patients. In addition to the physical divide between two groups of patients, the issue of labelling and the use of language more generally appeared to be important in enabling doctors to manage the feelings of discomfort created by the requirement to contain patients who were unlikely to leave and field norms concerning recovery as an objective for each patient. Beyond an explicit acknowledgement of the importance of language in selling certain types of 'long stay' services to patients, many doctors also resisted the label 'long stay' which was itself a euphemism for permanent stay. Facilities were called variously 'slow stream rehabilitation', 'enhanced recovery', 'sustained care' and 'continuing care' and in one site where 'long stay' and other patients were not separated, individuals who had been treatment resistant for many years were offered 'integrated therapy', which did not involve any psychological or medical interventions for *'people with personality disorders… because it is not as treatable'* (ID3) as other conditions. This involved discussing, for example, communication skills with an occupational therapist, but the necessity of giving it a label and defining it as a specific 'therapy' can be interpreted as reflecting anxieties about cessation of treatment.

The euphemisms for long or permanent stay appeared in some cases to be an attempt to disguise the potentially permanent nature of these facilities to make them more palatable to patients, but they also appeared to relate to an unwillingness on the part of doctors to accept the implications of such facilities. Some doctors acknowledged that the needs of the two groups of patients were different, but felt unable to state openly the implications for some patients. Accounts reflected conflict and ambiguity with some doctors describing the need to maintain hope and not accept that people will not move on and seconds later outlining how patients who will never move on were managed within the system. Linked to this, in one

case 'recovery' was given a different meaning, so that it was no longer associated with moving on and transition. Instead it was described in terms which resonate with the quote from an older doctor earlier in the paper about a shift from cure to care.

'we've called it Enhanced Recovery Service ....we want to maintain some realistic hope for some guys, but we've also got to make it pleasant and a good quality of life and optimising people's recovery for some of those guys who aren't going anywhere and women, in the future'. (ID5)

Discussion

Our study describes changes occurring in the field of forensic mental health which were not of an immediate or sudden nature, but emerged over time. Yet these were more rapid and involved more planning than Bourdieu's view of small improvisational changes at the margin would suggest. The impetus for change appeared to arise from feelings of unease with current arrangements, but changes also produced feelings of unease. Enduring dispositions to treat and cure, which are shaped by structures and past events, help shape perceptions of current events. Such dispositions are reinforced by doctors' experiences of patients moving on through the system, but not all patients will do this. Psychiatrists continued to emphasise the importance of treatment yet there appeared to be a growing perception, at the level of embodied practice, although not necessarily explicitly articulated, amongst many doctors that 'recovery', defined as cure, was not a suitable aim for many patients. For doctors whose rationale is provision of treatment, the requirement to care for patients for whom no effective treatment exists and/or for whom treatment can be provision of 24 hour nursing care creates unease and discomfort. When it comes to treating patients who are not 'long stay' residents, the 'rules of the game' have not changed, but for long stay patients, these 'rules' are not such a good fit. If the experience of patients moving on reinforces dispositions to treat, then the failure of patients to move on may detract from that process. Perception of this failure takes

time, given the nature of treatment, which even for 'successful' patients, can take several years. Over time, the alignment between habitus and field begins to weaken. This creates space for agency and prompts consideration of alternative arrangements, although the extent to which this occurred varied between individuals. For some, acknowledgment of problems translated into action which led to new forms of practice.

Doctors viewed the changes they made as resulting in more appropriate environments for patients. At the same time their responses indicated a high degree of unease relating to the implications of these service changes. The tendency in fields towards reproduction and stability (Bourdieu 1990b) helps to explain why radical changes were not pursued, despite the fact that these more moderate changes were associated with feelings of discomfort. Few doctors advocate a Netherlands-style approach. Given the unease related to reducing psychiatric treatment, a radical change such as this would result in a pronounced schism between habitus and field. Probyn (2004) suggests that in relation to conflicting emotional responses, the role of the habitus is to sort out confusion and 'reproduce the feeling of inevitability'. Yet there might be times when 'feeling shakes up the habitus; when the body outruns the cognitive capture of the habitus' (2004:232). In our study, it appears that feelings of unease which have the potential to disrupt habitus do not jolt doctors into sudden action, but that this process is a much more protracted one.

Doctors feel uncomfortable with treating all patients as likely to leave but they also feel uncomfortable with 'warehousing' patients or acknowledging that some are unlikely to leave. The changes do not eradicate field tensions, which create 'insecurity and anxiety' (Bourdieu 1991: 79), but coping with these feelings appeared to be characterised by an increasing degree of euphemisation on the part of field agents. For our study participants, language was important in the process of legitimising change and conveying to others that new forms of service provision did not entail giving up on recovery. For Bourdieu all discourses are

euphemisms to some extent (Bourdieu 1991). The use of euphemisms as a form of self-censorship did not appear to be the product of a consciously calculating set of 'rational' actors, since no attempts were made to conceal contradictions or provide coherent explanations to reconcile tensions in accounts. At the same time, ways of speaking are not neutral and psychiatrists' accounts can be seen as serving particular interests. In particular, they allow forensic psychiatry to maintain its position within the field, even where psychiatric interventions are being withdrawn.

Various commentators drawing on psychological theory suggest that feelings play an important role in influencing what it is that individuals pay attention to and act upon (e.g. Lazarus 1991). It has also been suggested that the extent to which people notice field contradictions is linked to their mindset, with 'socialised knowers' who are reliant on others for their sense of self less likely to attend to contradictions than 'self-transforming knowers' who embrace conflict as an opportunity for self-learning (Voronov and Yorks 2015). However, the differences in attitudes and degree of comfort in talking about contradictions in our study appeared to be linked to generational differences. In general, older doctors were more open in challenging the idea of recovery as meaning discharge for all patients. Whilst 'post-Clunis' doctors were described as colluding with the state's public protection agenda, their accounts, with an emphasis on treatment and recovery, rather than permanent incarceration might be interpreted as influenced by field structures, such as norms of medical professionalism and RCP guidance that emphasises health gain, rather than incarceration. The contrast drawn by older doctors, who exhibited less discomfort with a move to care rather than cure, can be explained in part by the different training and socialisation experiences which appear to have informed subsequent practice in different ways. In other words, differences in responses by field agents who occupy similar social positions and draw on similar forms of capital may be explained in part by different pasts, which have implications

for future imagined and enacted practices. Differences between generations reflect 'not age-classes separated by natural properties, but habitus which have been produced by different *modes of generation*' (Bourdieu 2007:78 emphasis in original). The fact that commissioners were more open in challenging existing provision also suggests that habitus and its relation to the field, rather than possession of a particular mindset, is influential here.

The remarks by one doctor about *'getting high secure units to start wanting to help people…..'* suggest that for those staff '*doing sod-all*' did not cause them anxiety, yet it troubled him deeply. This illustrates that more is involved here than a process in which bodies produce feelings as reactions to stimuli and then make sense of them. Feelings of discomfort must be seen in the context of field tensions, but the role of the habitus goes far beyond 'sorting out confusion' relating to what bodies feel (Probyn 2004: 232). Although Bourdieu did not explicitly theorise feelings in this way, our data suggest a more dynamic process with the habitus playing a key role in structuring what people pay attention to and how they perceive it (Scheer 2012), as well as whether they experience particular feelings in the first place, therefore.

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