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Discovering Mental Ill Health: 'Problem-Solving' in an English Magistrates' Court

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CHAPTER 33

DISCOVERING MENTAL ILL HEALTH: 'PROBLEM-SOLVING' IN AN ENGLISH MAGISTRATES' COURT

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Introduction

In this chapter we examine one particular approach to problem-solving in the English criminal justice system. The incorporation of problem-solving into Magistrates' Courts for low risk offenders has been called a 'window of opportunity' (Donoghue, 2014) insofar as it provides an opportunity to engage with 'hard-to-reach' social groups. It aims to identify any problems which are acting as barriers to a better life and signpost the person to services which can help address these problems. One of the aims of the project that we have been conducting on community justice is to examine how problem-solving works as a specific set of practices for those with mental ill health problems.

Mental ill health and criminality

The association between mental ill health and criminality has been noted for many years (Bradley, 2009). Though estimates vary, many studies indicate that there is a higher than normal incidence of people with mental ill health problems processed through the criminal justice system. The Centre for Mental Health (2014) suggests that the incidence is 70% whilst others suggest that it is closer to 90% with considerable co-morbidity (Scott & Moffatt, 2012). In contrast, based on a stricter clinical definition of 'severe mental disorder', Fazel and Seewald, (2012) reviewed studies of prisoners from 24 different countries and found a pooled prevalence for psychotic illness of 3.7% and for major depression of 11.4%.

These statistics largely relate to incarcerated offenders. However, in the UK, the majority of those convicted of an offence appear in the lower courts or are processed out of court by the police (Ministry of Justice, 2014a). There are fewer statistics on the mental ill health status of these people. Cattell, Mackie, Prestage and Wood (2013) estimated that 29% of offenders who were placed on a community order had a mental health condition.

In sum, poor mental health has been identified as a significant pathway that leads into criminality, alongside other life circumstances associated with social exclusion, such as substance misuse, debt, lack of or poor housing and relationship problems (Byng et al., 2012; Ministry of Justice, 2010, 2014b).

Community justice

In part, as recognition of the likelihood of multiple problems affecting those appearing in the courts, there have been initiatives designed to do more than simply prosecute and sentence offenders (Rogers & Pilgrim, 2014). One such intervention has been through community justice courts (Attorney General, 2009). These types of court originated in the USA during the 1990s and the principles established there have in turn influenced a number of similar developments in England and Wales, most notably the North Liverpool Community Justice Court (Mair & Millings, 2011). Community justice emphasises solving crime problems and improving public safety in the community, addressing the needs of victims and solving problems associated with the individual offender in order to prevent them committing further crimes (Berman & Fox, 2009; Gilling & Jolley, 2012).

Project overview

The Magistrates' Court which formed the focus for this project is a community justice court which has a procedure for problem-solving. Magistrates have the option of offering offenders who have pleaded guilty, a 'problem-solving meeting' on the day of their hearing. This meeting is conducted away from the courtroom by a separate problem-solving team who identify any underlying problems experienced by the offender and which may have contributed to their current offence. It is during this meeting that any mental health issues may be raised with a view to identifying an appropriate course of action. The problem-

solving team report back to the Magistrates about any outcomes from the meeting which are then taken into account when sentencing.

The meeting is structured around a form which identifies a number of topics related to social exclusion including general and mental health. Other questions identify issues such as accommodation, finances, relationships and substance misuse. Over two thirds of those who undertook a problem-solving meeting in a one year period reported that they experienced more than one of these problems and also self-identified as having a mental health problem. The aims of the support service which runs the problem-solving intervention are to identify vulnerable clients and their problems, signpost them to appropriate services and to monitor and follow up their progress. It offers a combination of practical help with administrative issues such as benefits and fines and support in accessing long-term support for chronic problems.

A corpus of 22 audio-recorded meetings was assembled; most meetings lasted between 20 and 40 minutes. From these meetings, we made a collection of 42 extracts in which mental health was referenced by the participants. We focus on how mental health issues were raised by members of the problem-solving team members and then how signposting is implemented. Overall our question is: how is this meeting implemented in practice in terms of the identification and signposting of mental ill health problems?

Findings

In the prior section we have provided a brief summary of the evidence on the prevalence of mental ill health in the criminal justice system. Though there is debate about the extent and nature of this relationship, we also argue that it forms part of the background social and cultural knowledge that those working in and for the courts have for sense-making and suggesting courses of action. For those involved in court cases there is the issue of

particularisation: ‘Does this particular person have a mental health problem, if so what is it and what is the appropriate course of action?’ This particularisation requires a form of ‘practical epistemology’ (Kidwell, 2009) which engages everyday interactional procedures to accomplish agreement (for all practical purposes) on the state of mind of the offender. It is particularly salient for those conducting problem-solving meetings as they have been charged with the institutional job of identifying ‘problems’ and the courses of action which might follow. This practical epistemology is built around the topics identified in the meeting form and the type of questioning it generates.

Within conversation analysis, questioning has been a widely researched practice particularly in institutional settings (Freed & Ehrlich, 2010). The complexity of questions as discursive objects has been noted by, among others, Steensig and Drew (2008): “*[It’s] plain that whilst an utterance may be formed interrogatively, and indeed may ‘question’ the recipient, the utterance simultaneously does or ‘performs’ another action. ‘Question’ is therefore only a minimal characterization of an utterance, interactionally*.” (p. 6) Moreover, questions can take a wide range of forms (Enfield, Stivers & Levinson, 2010) which in turn, interact with the action orientation of the question (Raymond, 2003). Heritage, (2003, 2010) has identified four key dimensions of question delivery which are relevant to different institutional encounters: agenda setting, embodying presuppositions, conveying epistemic stance and incorporating preferences. These dimensions will form the basis for our own analysis of the practices for the identification of mental ill health status amongst offenders who appear before the Magistrates’ Courts and undergo problem-solving. In the first part of the analysis we examine the questioning formats through which problems of mental ill health are identified. In the second, we examine how questioning is designed as part of ‘diagnostic procedures’ which lead into advice giving.

Questioning and the discovery of mental ill health

Overwhelmingly potential cases of mental ill health were constituted through being raised as a topic drawn from the problem-solving form. Of the 22 problem-solving meetings in our corpus, only five did not include a sequence about mental health which was not form-initiated. The form on which the problem-solving team member recorded summaries of answers, structured the 'institutional noticing' (Ehrlich & Freed, 2010) of potential problems or criminogenic factors in the offenders' lives. To this extent they conform to Heritage's (2010) identification of questions as agenda setting devices. Here we give three different question formats through which mental health was topicalised; these formats are differentially oriented to optimization or problem-attentiveness. Consequently, they generate different trajectories for the identification of mental ill health.

Content question topicalisation

Extract 1: (PS04:11)

327		(0.7)
328	PS[1]	okay (0.3) er↑::m (0.4) wha- ho::↑w's <you:r> (.) general
329		health (.) ↑↑good
330	Off	>fine< (.) yes
331		(6.1)
332	PS →	and ↑mental ↑health?
333	Off	fine >in my< opinion y[es
334	PS	[yea:h,

[1] In all extracts, 'PS' refers to a member of the problem-solving team; these members included police officers and members of a third sector organisation. 'Off' refers to the offender who has been sent out by the court to engage in problem-solving.

Extract 2: (PS18:36)

135		(15.6)
136	PS →	what's your ↑general health like,
137		(1.5)
138	Off	I see:m alr↑ight .pss
139	PS	ye::h you look al↑ri:ght
140		(5.7)
141	PS	an' whaddabout you::r (.) me:ntal health
142		(0.5)
143	Off	fine as far as I'm a↑ware

In both these extracts the topic of mental health is raised through a content question either 'how's your-' or 'whaddabout your-'. Both these questions come after a lapse in the progressivity of the meeting and both questions are tied to a prior question on 'general' health through the tying conjunction '*and*' (Heritage & Sorjonen, 1994). Mental health in these sequential contexts is constituted as part of a larger package on health status.

Fox & Thompson (2010:135) have distinguished two types of content question: specifying and telling. Specifying questions request specific types of information whereas telling questions seek extended responses. The distinction between 'specifying' and 'telling' mirrors that of Kidwell (2009) who has identified 'filling-in' questions where the task of the responder is to specify or fill in an item of information, and 'filling out' which is designed to elicit a more elaborate answer from the responder's perspective.

In the extracts here, the questions are both formed as and treated by the recipient as specifying questions. In extract 1, the type of specifying response is indicated by the

candidate answer that immediately follows the '*wh*-' question (1:329: 'good') which is then mirrored in the response to the first question and its tied follow up (1:330, 1:333). This response indicates that the delivery of the question was understood as 'optimizing': *"This principle embodies the notion that, unless there is some specific reason not to do so, medical questioning should be designed to allow patients to confirm optimistically framed beliefs and expectation about themselves and their circumstances."* (Heritage, 2010:52). There are two clues as to why these sorts of questions are optimistically framed. First, the questioner gives a candidate answer tilted toward an optimistic assessment (1:329) or gives a second assessment to the epistemically downgraded first assessment (2:139). This second assessment has an agreement token and upgrades the evidential 'seem' to the stronger 'look'. It is also delivered as a straight declarative which implies that this was an assessment made independently by the questioner (Heritage & Raymond, 2005) thus ratifying the offender's assessment. Second, Fox and Thompson (2010) suggest that there can be two types of response to specifying *wh*-questions: phrasal and clausal. Following Schegloff, they argue that the standard response to specifying questions is phrasal. Where a clausal response occurs it is inferenceable as identifying problems with the presuppositions in the question. In both extracts here the response is phrasal ('fine', 1:333, 2:143) although they are both then epistemically downgraded through an evidential qualifier.

Topicalisation through question cascades

Question cascades were identified by Clayman and Heritage (2002) as a package of questions which normally start with a content question but are immediately followed by second or third questions which 'revise and tighten' the presuppositions in the first question. Moreover, the second or third questions are usually formatted as yes-no interrogatives (YNI). They

proposed this type of questioning is a particular practice in political interviewing designed to challenge the interviewee.

Extract 3: (Clayman & Heritage, 2002:757)

```
Int:      Mr. President, you mentioned a moment ago your receiving
          reports of apathy among voters.
     Q1   To what do you ascribe this apathy?
     Q2   Is it a disenchantment with the program of the last 2
          years, Sir?
```

We do however find that question cascades are a frequent way in which mental health is topicalised and identified in the problem-solving meetings. Though not necessarily an adversarial move as in political interviewing, they do take the initiative in specifying the categories of mental ill health expected as candidate responses.

Extract 4: (PS05:12)

```
285              (1.2)
286  PS   Q1     (or) >what about< your mental health
287       Q2     do you suffer from any kind
288              of dep↑ress:ion or anx↑i:ety: or::
289  Off          °°no gh°°
```

Extract 5: (PS10:21)

```
211              (6.5)
212  PS   Q1     °okay↓° >and what about< you:r me:ntal health hh .h
213       Q2     have you ever suffered fro:m depression <o:r
214              .hhh anx↑iety, >panic attacks<,
```

215 Off no:::

216 PS ↑no

217 (2.1)

In these extracts there is an opening content *'wh-'* question which does the initial work of topicalising mental health. The content question is immediately followed by a YNI formatted question. There are two noticeable features of these YNIs. First, in common with other ways of topicalising through question cascades, the second question revises and tightens the available categories of mental health. Just as in the presidential questioning the 'apathy' is presupposed in the second question to be attributable to 'disenchantment', so here, the mental health problem is constrained to specific categories of mental ill health: in this setting, normally depression and anxiety.

The second noticeable feature is the preference organisation of the second questions. Questions which contain negative polarity items (e.g. 'any', 'ever') prefer disconfirming responses (Heritage, 2010). Again the principle of optimization underlies the design of these second questions. They are oriented toward a no problem or positive outlook for the offender. In each case the responses are disconfirming, delivered with preferred turn shapes with the responders aligning themselves with the presuppositions of the question (Raymond, 2003) suggesting that both participants are oriented to the optimistic presuppositions of the question.

In contrast to second questions with negative polarity items, question cascades also allowed for more elaborative responses. In these cases the second question was a straight interrogative which can be heard to favour a confirming response. In addition, these questions more clearly orientate to an 'unknowing' stance on the part of the questioner which can in turn "… invite elaboration and sequence expansion." (Heritage, 2010:49)

Extract 6: (PS01:02)

498			(12.6)
499	PS	**Q1**	°°okay°° ↑what about your me:ntal health (0.4)
500		**Q2**	↑d'you ↑suffer ↑from ↑de↑pression?
501			(1.6)
502	PS	**Q3**	or ↑stress,
503	Off		↑no:t
504	PS	**Q4**	you seem quite lo:::w (0.4) °if you don't mind° me saying,
505	Off		°it's cos I've got ( )° (.) I'm ↑not saying I (feels)
506			depressed but I do: (.) they reckon I'm (.) au↑tistic,

Extract 7: (PS08:19)

102			(2.0)
103	PS	**Q1**	okay (.) and ↑how's your mental health,
104		**Q2**	(.) do you have ↑anxiety or ↑depression
105			or [↑stress ( )?]
106	Off		[no I suffer] from a
107			bit of depression °but°

Extract 8: (PS15:29)

315	PS1	↑I'll get you an >ayay< leaflet as well which tells you
316		about [the-] [the (.) al anon]
317	Off	[okay]

318 PS2 **Q2** [.hh is ↑↑you:r] general health and (.)

319 °mental health okay°,

320 Off I d- I::er ye:ss I erhm I'm fi:ne in that res↑pect,

321 er >I get a bi,t< (0.4) depressed

322 >because of the< (0.4) [sss s] [ss:]

323 PS2 [↑yeah]

324 PS1 [>wh]at your living with<

The key question is the YNI labelled Q2 in the extracts[2]. In extracts 6 and 7 the second question similarly revises and tightens the categories of mental ill health to depression, anxiety and then more generally 'stress'. However, these second questions do not have the negative polarity items identifiable in the previous set of extracts, as a consequence they elicit more elaborative responses.

In extract 6, the turn initial discourse marker (*okay*) and the *wh-* question establish mental ill health as a new topic and set up a slot for the immediately subsequent YNI cascade question. The cascade question provides for a preferred response as constrained to confirming or disconfirming 'depression' as a category of mental ill health. The gap (6:501) can be heard as preliminary to a dispreferred response; one which is likely to take issue with the presuppositions in the question (Raymond, 2003). The problem solve team member then asks a second YNI ('or stress') as an alternative candidate response, though this term has moved away from a strict mental ill health category toward a more quotidian source of distress. The offender makes a move to respond with 'not', again anticipating a dispreferred response, the problem solve team member offers an assessment of the offender's state of mind using

[2] We have included extract 8 in this section as, although it does not strictly conform to a question cascade format, it has the straight interrogative format of second cascade questions and as such can be seen to be doing similar work in so far as it allows for elaboration and sequence development.

another quotidian term ('low') rather than a 'technical' psychiatric term. It is also qualified by the use of the evidential 'seem' and acknowledges the sensitivities around making claims about other people's state of mind. This can be heard as a third question, in so far as it indexes the lower epistemic status of PS and although delivered as a declarative is oriented to confirmation or disconfirmation. The three cascade YNIs move from a steep epistemic gradient in terms of the stance of the two actors to a more shallow gradient, where PS makes a tentative 'B-event' claim to know the state of mind of the offender, thus intruding onto the epistemic territory rightly known by the offender (Heritage, 2012).

These steps in the cascade and the final assessment (Q3) display PS' receptivity to the likelihood of a mental ill health problem. The systematic downgrading of the category term used as well as the move to a declarative format in the final assessment, display the work to elicit a suspected problem. Thus in contrast to the earlier optimizing formats for topicalising mental ill health, this format is more 'problem attentive' (Heritage, 2010). Though the nature of the problem is eventually formulated in quotidian terms, the use of the descriptor 'low' affords the possibility of any agreement with this assessment to be recategorised formally as 'depression' or related mental ill health term.

Further in extracts 7 and 8, the offender has the opportunity to elaborate their response to the YNI. The initial response to PS' question is *pro-forma* agreement with the presuppositions of the question (7:106; 8:320), followed by an elaboration of a mental ill health problem. Probably as a concession to the preference organisation of the question, this elaboration is produced using a palliative format (Schegloff, 2007) so that the full force of the mental ill health claim (depression) is downgraded by the qualifier '*a bit (of)'*. Nevertheless, this question design provides more opportunity for the recipient to identify and elaborate their mental ill health problem.

Prior-informed topicalisation

With this format of questioning, PS is fully engaged in a problem attentive exchange. Built into the question is PS' own understanding of the mental ill health problems of the offender. At some point earlier, PS' epistemic status with regard to the state of mind of the offender has been upgraded so at the point of this exchange there is evidence of a mental ill health problem. This upgrading most often occurred either through evidence given in the court hearing or through a claim made by the offender earlier in the meeting.

Extract 9: (PS03:07)

370	PS	okay: what's your general health like <you look (.)
371		fairly healthy ↑yeah no iss[ues]
372	Off	[no::] yeah. °juss-°
373		(2.1)
374	PS	↑no ↑anything [(ongoing ↑no)]
375	Off	[no I'm fine] just erhh
376		depression and anxiety
377		(and stuff) [( )]
378	PS	[oh well th]at's mental health
379		we'll come to that in a second
380	[7 lines omitted]	
381	PS	so (0.3) ↑mental health
382	→	you've got (.) >depression and< anxi:ety,=
383	Off	=hmm (0.7) at the moment (yes I think that's) ( )
384		(1.2)
385	PS	right.

Extract 10: (PS02:05)

545		(9.1)
546	PS	okay and as a result of that (.) your >me:ntal health<
547	→	(1.1) did you say you- you suffer from depression,
548	Off	yea:h uh:m I've [suffer-
549	PS	[(is that ↑medi↑cated)

In both these extracts PS gears their question to specific categories of mental illness attributable to the offender. These categories have been claimed earlier in the meeting by the offender and when the orderly slot for addressing mental health arises (9:381) PS issues a question which acknowledges and displays their understanding of the offender's claim to a mental ill health problem. These question designs have a strong preference for agreement and are problem attentive aligning with the offender's prior claim and as such allow for further elaboration and expansion in the responsive slots.

Problem attentiveness was also evident when PS brought to bear their own understanding of the sort of world that the offender might occupy, which allowed them to make inferences about the likely problems experienced by the offender. Thus PS' epistemic status as knowledgeable and experienced in criminogenic matters allowed them to display insight into the offender's own life-world and so probe for a particular 'ontogeny' (cf. Kidwell, 2009) of how a mental ill health problem came about.

Extract 11: (PS13:25)

310	Off	=an' I said [(Elizabeth) (ba- off)]

311 PS [what about yo]ur mental and

312 gen- your- your general health <is that ↑good?

313 → have you got any issues because of [thuh (.)] ↑drugs?

314 Off [pwhhhhhh]

315 (0.8)

316 PS has i[t left you with any↑thing?]

317 Off [na- not cuz of]drugs b[ut,]=

318 PS [↑no?]

319 Off =I would say (.) emotionally (.) I'm a wre:ck,

320 (.)

321 PS right so your ↑mental hea:lth

322 Off done in (.) I am- I'm done in (.) I ca- ca- can't

323 believe (0.4) you a::sk someone for help an- and

324 they screw you over like the:y 'a:ve

325 PS so it's a de↑pression

326 (0.4)

Extract 12: (PS16:33)

234 PS ↑ri:ght

235 (0.4)

236 Off [( )]

237 PS [what dju-] your >↑general ↑health

238 → and your< me:ntal health obviously very much affected by

239 your alcohol[ism °aren't they° so] you've got=

240 Off [yeah yeah it is ( )]

241 PS =<depre::ssi::on> (0.5) ↑↑yeah (0.3) [↑pa]ranoi::a,

242 Off [yeah]

243 (0.6)

244 Off very paranoid (tha:t's) [smoking w]eed and=

245 PS [well that's]

246 Off =[shi:t like tha]t<(I got to put me hat) ( )=

247 PS [( ) yeah]

In both these extracts PS uses a cascade question form where the follow up questions (arrowed), tighten the ontogeny of any mental health problem through a question which presupposes the likely role of various forms of substance misuse. In extract 11, the offender can be heard to be moving toward a dispreferred response (anticipated for example by the loud outbreath; 11:314) negating the presupposition that his mental health is 'good' and then goes on to counteract the presupposition that the 'drugs' have been implicated in his problems. Nevertheless, the orientation of the cascade question toward confirmation and the identification of a likely source of the problem allows the offender to elaborate his problems. It is worth noting here too that PS receipts the offender's account with a formulation (Heritage & Watson, 1979) which deletes many characteristics of the problem as described by the offender and transforms those problems into a clear mental ill health category (11:325: 'so it's depression').

In extract 12, the cascade questions are strongly oriented toward confirmation displayed by the qualifier ('obviously') and the negative tag question. The 'so' (12:239) is a causal conjunction which links the substance use to specific mental ill health categories. This offender orientates to and affiliates with the criminogenic ontogeny proposed by PS and sequentially expands upon this proposal (12:244-6: 'that's smoking weed and shit like that').

Summary

These question formats are recipient designed and their probabilities of eliciting a claim to a mental ill health problem are quite different (Table 33.1). Through these question formats, there is a continuum from optimization through to problem attentiveness and this continuum is indexed in the syntactic and lexical design of the questions. In addition the issue of epistemic status and stance are evident, in so far as problem attentiveness is often accompanied by an epistemic encroachment into the territories of knowledge which are rightly the domain of the offender.

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Table 33.1 about here

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'Diagnostic procedures'

In the previous section we saw the practices through which mental ill health problems are identified; a second function of problem-solving is to 'signpost' offenders to other specialist services. For problems associated with mental ill health these services were dominantly general practitioner, voluntary counselling services and drug and alcohol services. Elsewhere, we have identified that over 75% of signposted referrals arising from problem-solving meetings were to the person's GP.

Signposting can be thought of as delivering advice whereby one participant: "... describes, recommends or otherwise forwards a preferred course of future action." (Heritage & Sefi, 1992). Heritage and Sefi identify three discursive dimensions of advice delivery: step wise progression into advice, a normative dimension, and a competence or epistemic dimension. First, advice is rarely delivered 'cold' but there is a lead in which establishes the nature of the

problem or whether past actions have been taken to address it (Butler, Pooter, Danby, Emmison & Hepburn, 2010). Second, advice constructs an obligation on the part of the recipient to undertake it. Third advice is delivered on the basis of the superior knowledge and competence of the advice giver. Subsequent studies have confirmed the generalizable status of these features across different institutional and informal settings (Vehviläinen, 2001; Pilnick, 2003; Shaw, Pooter & Hepburn, 2015).

In our collection, one of the standard ways in which 'signposting' is accomplished is a step-wise, 'diagnostic procedure' which acts as a pre-sequence to the delivery of the advice itself. This diagnostic procedure tended to have: a sequence of yes-no interrogatives, tied together with standard conjunctions '*and*', contrastive '*but*, and causally connective '*so*' (Heritage & Sorjonen, 1994; Schiffrin, 1987). The question contents and the sequential way in which they were linked displayed an 'expectable standard' (Heritage & Sefi, 1992) against which advice can be fitted. The main functions to which this diagnostic procedure was addressed were: identifying particular aspects of the problem which were potentially actionable and which give entry to advice delivery; normalising an initial claim to mental ill health; and identifying more precisely a mental ill health problem (see Extract 11).

'No problem' claims

We start with claims made by offenders in responsive turns that there is 'no problem' with their mental health. Despite this claim PS embarks on a diagnostic procedure, which draws upon their own epistemic status as knowledgeable about criminogenic matters to explore candidate factors associated with mental ill health problems. These factors bring together prior information that the offender has provided with the current agenda item on mental health. This diagnostic procedure, embarked upon despite a no problem response, displays

the institutional constitution of problem-solving as one which requires checking of all aspects of the person's current life circumstances.

Extract 13: (PS05:12)

286	PS	(or) >what about< your mental health
287		do you suffer from any kind
288		of dep↑ress:ion or anx↑i:ety: or::
289	Off	°°no gh°°
290	PS	you look pretty chilled a:ctually (.) °to me°
291		↑after you've been out on a bit of a bender
292		on the alcohol do you feel a bit low the ↑next ↑day,
293		(0.5)
294	Off	°°no (I'm ok)°°
295	PS	↑no
296	Off	no
297		(1.7)
298	PS	°okay°
299		(6.1)

In this extract PS identifies a potential source of trouble which may defease the no problem claim founded on prior lifestyle information but reinterpreted as a cause of or allied to mental ill health. After the offender's 'no problem' response (13:289), PS independently assesses the offender's mental state aligning with this no problem claim. Within the same turn, however, PS proposes a candidate cause of depression (excessive alcohol can lead to feeling 'low') although the term used is one drawn from a non-technical emotion language game. Following its denial, PS provides an other-initiated repair designed to invite a revision of that response.

It receives the same negative response and PS receipts this with a newsmark leading to closure of the topic and a lapse in the progressivity of the meeting.

There are two noticeable features of this extract. First, there is a background presumption that mental ill health is present for these clients and as such there is an imperative to explore all avenues which might confirm that presupposition. Second, in cases of no problem responses, the offenders are required to do more than simply deny having a mental ill health problem, they have to respond to further questioning embedded within the diagnostic procedure implemented by PS. The upshot of the trajectory of these diagnostic procedures is to 'normalise' the current lifestyle of the client.

Diagnostic procedure as step wise move into advice

Our final extract shows more clearly how an extended diagnostic procedure explores different aspects of the mental ill health problem with a view to identifying an anomaly which is amenable to the delivery of advice.

Extract 14: (PS11:23)

268	PS	oka:y u:m (.) ↑what (0.4) ↑what about your mental health_
269		(0.6)
270	Off	[i:t's]
271	PS	[( )] depre↑ssion or ↑anything ↑like ↑tha::t?
272		[↑has ↑doctor ↑William] ever picked up on anything=
273	Off	[( ) I thi::n-]
274	PS	=li[ke tha:t,]
275	Off	[yea:h I've] ↑bin e::r, (0.6) er depressed (where)
276		I'm feeling do:wn an- that a few ↑times,

277 PS what ↑recently or in the p[a:st]

278 Off [yea:]::h la:st yea:r was

279 the last time ↑like, (0.6) I we[nt there,]

280 PS [did ↑you] ↑speak to

281 ↑doctor ↑William a↑bout ↑↑i::t?

282 Off °yeah°

283 (0.4)

284 PS .hh did he, (0.4) medicate you? [↑or ↑any]thing?=

285 Off [yea:::h,]

286 PS =>°↑give ↑you ↑anything?°<

287 (1.4)

288 PS and ↑that's ↑done no:w is ↑i:t?

289 Off yess, (0.6) but obviously I, (0.4) [( )]

290 PS [but you think]

291 you're sti:ll, (0.4) (suffering from a) bit of

292 de↑pression

293 Off maybe I do[::]=

294 PS [ye]ah,

295 Off =↑some days I feel alright and some da:ys I, (.) just

296 feel ↑down ↑l[ike (ho]ne:st)

297 PS [↑mm:::]

298 PS ↑I ↑would ↑ad[vise you↑ go ↑back] tuh yea::h,=

299 Off [( ) really but,]

300 PS =go back to hi:m, (0.6) if ↑he's been your gee pee

301 for a num[ber] of years then [there's probably] ↑nobody=

302 Off [yeah] [yeah he ↑has,]

303 PS =.hhh medically (0.4) qualified there's [nobo]dy better=

304 Off [yeah]

305 PS =.hhh than hi::m,

306 Off yeah yea::h

307 PS because he knows your situation he's watched you grow up

308 he knows w[hat] ↑whe:re you're at no:w, .hhh (0.4)=

309 Off [yeah]

310 PS ↑so ↑do ↑you think you might make another appointment

311 with [↑hi:m?]

312 Off [yea::h]

313 PS ↑yeah? (0.8) it'll certainly he:lp,

314 (19.2)

This is a lengthy extract with many noticeable features. We however draw particular attention to the following features of this exchange. First, following the claim of a mental ill health problem (14:275-6) PS launches a series of questions concerned with identifying any problems with the offender's current mental state. These questions are typically YNIs or alternative questions and for the most part they receive straightforward confirmations. In this case this series of questions reveals a potential problem whereby the treatment received was over a year ago (14:278-9) implying that the mental ill health problem might be unresolved or have returned.

This implication about the potentially problematic current state of mind of the offender is picked up in series of questions linked through the conjunctions '*and*' (14:288) and *'but*' (14:290). These questions are both designed to prefer a 'yes' response (14:288: tag question 'is it' and 14:290-2: declarative question) displaying the problem attentive orientation of the diagnostic procedure. Moreover the questions convey an 'expectable standard' of what the

offender's current state of mental health should be and how it should be addressed (e.g. 14:284-6, 14:290-2). Once the offender has confirmed the current problem, PS responds with advice delivery (14:298-300: to make a return visit to the GP). PS uses a term of overt recommendation softened by the use of the modal auxiliary (14:298, I would advise).

The next move by PS displays some of the dilemmas of providing advice in this context. Though there is a normative orientation to taking up the advice, PS team members do not have any official powers to enforce that recommendation (cf Butler et al., 2010). Problem-solving is only likely be effective if the person follows through on the advice. The normative pull of this advice is upgraded through an account of the expertise of the GP in terms of the benefit to the recipient. PS articulates the qualifications of the GP as a medical practitioner as well as the personal knowledge that the GP has of the offender implying that the GP can tailor any treatments specifically to the offender. The advice is then reissued as YNI about the offender's future intentions, which in turn is accepted and then evaluated in positive terms by PS (14:314: it'll certainly help).

Summary and clinical relevance

This analysis has aimed to show how claims and attributions of mental ill health are interactionally constituted. The identification of categories of mental ill health and the advice that is built out of a diagnostic procedure is accomplished through the action sequences in which both the offender and the problem-solving team participate. The background to the identification of mental ill health problems is the widespread understanding that those with such problems are over-represented in the criminal justice system. This assumption is often displayed in cross-cutting preferences (Schegloff, 2007) in the sequences analysed here. On the one hand 'optimization' can be built into the question form preferring a 'no problem' response, yet such a response is often followed by a diagnostic procedure which invites

revision of that response. This suggests that there is a conflict between the interpersonal dynamics of presuming no problem and the institutional presumptions of 'problem-solving'.

There are a number of clinical implications of this project. First there are implications arising from the analysis itself which would allow those involved in problem-solving to reflect more fully upon the practices currently used to identify mental ill health. There were different questioning formats which were related to different response trajectories, from optimizing 'no problem' responses to problem attentive expansion of mental ill health problems. These formats were clearly recipient designed, though the motivation for these designs were likely to stem from different sources. At one level they would be contingent upon the sort of information that had been gleaned from earlier interactions, at another they would arise from the degree of cooperativeness of the offender, and at yet another the problem-solving team members are constrained by the institutional requirements to provide a summary and feedback to the court within a short time frame. A current model of training which would be applicable here are those based on the principles of CARM (Stokoe, 2011).

The second implication arises from recent developments in the clinical professions themselves which could be used to develop problem-solving team members' understanding of how mental health assessments are made. Thus it is possible that training could be developed which builds on current clinical psychology understandings of mental ill health in terms of formulation as opposed to diagnosis (Johnstone &Dallos, 2013) and so avoiding over-prescriptive psychiatric categories.

A third implication is that those within the clinical professions can gain a better understanding of how mental ill health is assessed and identified amongst largely hard-to-reach social groups. The problem-solving meeting is a particularly good opportunity to engage with such groups in settings outside the surgery or clinic. A recommendation which

followed the Bradley Report was the establishment of the Mental Health Treatment Requirement (NOMS, 2014) as a community order option available to Magistrates. However, Scott and Moffatt (2012) note that this order is chronically underused (less than 1% of all community order requirements) suggesting that in most Magistrates courts those with mental health problems are not obtaining specialist intervention as part of their sentence. The arrangements we have investigated here, where problem-solving is undertaken by a non-specialist team is an important corrective to this gap in mental health provision and suggests that a greater level of co-operation could be initiated between these teams and clinical professionals.

‘Clinical practice highlights’ box

- Incorporating a problem-solving procedure into the lower courts provides an opportunity to engage with ‘hard-to-reach groups’ and to explore mental health issues.
- It is worth considering how ‘problem attentive’ questioning can be incorporated more fully into the problem-solving meetings
- Form initiated questioning could be used more flexibly. Information about mental health is often revealed through discussion of life stories, where the offender is more likely to focus on the realities of their experience.
- A wider range of services might be considered for signposting.
- Improved training for these front line non-clinical staff in formulating mental ill health as a biopsychosocial phenomenon rather than simply a medical phenomenon.

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Table 33:1: Question type and identification of mental ill health

		Mental ill health problem claimed or ratified in next turn	
	Question type	Yes	No
Optimizing	Content question	1	3
	Cascade with negative polarity item	1	3
Problem attentive	Cascade – straight interrogative	4	0
	Prior-informed interrogative	7	0

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Glossary

Magistrates Court: The Magistrates' Court is the lowest level of court in England and Wales. All criminal cases begin in the Magistrates' Courts, which hear the less serious 'summary cases' such as common assault or motoring offences as well as some 'triable either way' cases such as theft. More serious cases (indictable offences) are forwarded to a higher level of court – the Crown Court.