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Title: “A risk worth taking”: Aftercare and deviance as iatrogenic concerns in accounts of forensic patients conditionally discharged to community settings

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Abstract
Patients leaving forensic psychiatric settings on conditional discharge are challenged to achieve successful community reintegration. Successful integration involves building support networks, not reoffending and making adjustments to fit in.

Aftercare and monitoring of patients by workers ostensibly assists community integration but is often dominated by concerns about possible harmful risk behaviours. These concerns are located in the individual and steps are taken to ensure intensive monitoring and, if necessary, swift return to hospital.

This paper shows that workers and conditionally discharged patients have contrasting views about risk in community living, some of which are associated with the provision of care itself. A discursive analysis of accounts, drawn from 59 interviews
with patients and workers, shows that fears about deviance weigh most heavily for the individual leaving hospital.

Aftercare with its focus on intensive regular visits by nurses, social workers, police and voluntary agencies works to ‘unmask’ the person to the wider community and sets them apart as someone in need of supervision. Discharged people express unease that this unmasking works in opposition to their attempts to begin new lives and reintegrate into communities, suggesting a significant iatrogenic risk associated with aftercare. Workers for their part are not indifferent to patients’ concerns but are themselves subject to imperatives of surveillance and control of risky individuals. Community integration has the potential to be an important mediator in future risk behaviours. However, intensive aftercare handled without regard for its wider visibility may work to jeopardise these attempts.

Keywords: Aftercare, deviance, forensic psychiatry, users views, iatrogenic risk
“A risk worth taking”: Aftercare and deviance as iatrogenic concerns in accounts of forensic patients conditionally discharged to community settings

Introduction
Achieving successful community integration is a significant challenge for people leaving psychiatric hospitals. Attempts to organise and deliver specific forms of services to assist people with this challenge have been a concern for some time (Stein and Test, 1980). Successful community integration involves building support networks, making social adjustments and establishing social bonding (Grusky et al 1985). This paper deals with people leaving forensic mental settings on conditional discharge many of whom were detained in high and medium security settings. In such circumstances the challenges of reintegration are exacerbated by lengthy periods living in remote institutions. In the UK forensic mental health services provide health and social care for people with enduring mental health problems who have usually been convicted of a serious criminal offence. These services provide secure care and treatment in settings ranging from national high security hospitals through medium levels of security in large geographic regions and finally more local services offering lower levels of security. Prolonged detention and long distances from home, increase social isolation and disconnect people from their support networks. Leaving hospital can be a time of increased anxiety. The person may have to re-establish contact with family and friends or create new networks. In social situations they may be called to account for deviance labels, offences and their enforced absence. Conditional discharge is a highly scrutinised form of post-hospital aftercare. It involves intensive monitoring by aftercare teams, police and social services to manage the potential risk posed by the person and to enforce their swift return to hospital. This focus on the
possible risk behaviours of individuals may however downplay risks they themselves are exposed to.

In England and Wales the *Mental Health Act 1983*(amended 2007) provides the Crown Courts with a range of dispositions when convicting people of serious criminal offences against the person in the context of a diagnosable and treatable mental illness. These include detaining a person for treatment (Section 37) and restricting discharge (Section 41). Where discharge is granted it is often on a conditional basis under Section 41 and is subject to supervision arrangements. These may include attendance for treatment, permitting access to living arrangements, attendance at organised day-time activities and restrictions on travel or contacting particular individuals. In all cases the Ministry of Justice retains the right to recall individuals to hospital where concerns about risk behaviours are raised.

There were 3,937 people detained in hospital at the end of 2008 classed as mentally disordered offenders and subject to restricted discharge (Ministry of Justice, 2010). There were approximately 1,500 admissions to these settings in 2008 showing a 3 percent increase on previous years. These figures include 343 people detained on Section 37 with restriction orders (Section 41). Street (1998) estimated that 88 percent of people on these sections are male with half being between the ages of 21-30 years old and the majority convicted of serious violent offences. The majority of those detained on hospital orders are under the category of mental illness although a proportion (between 3 and 5 percent) is admitted under the category of psychopathic disorder. Twenty-five percent of people conditionally-discharged between 1987 and 1990 were recalled to hospital due to concerns about risk behaviours or their mental health (Street, 1998). Recent data indicate that approximately 7% of those discharged
between 1999 and 2006 re-offended within two years of discharge (Ministry of Justice 2010). These data compare favourably with reconviction rates of those released from prison (Ministry of Justice 2011) although some caution should be exercised in direct comparisons as the rates for discharged mentally disordered offenders do no include all those released.

The concern to predict and manage possible future behaviours has become a central task of mental health services (Godin 2004). Calls for greater control and compulsion of people with mental illness to accept treatment because of possible dangerous behaviours bear little relationship to the actual risk presented which is much lower for instance than deaths in road traffic accidents (Taylor and Gunn, 1999). Lupton (1999) has highlighted the contrast between perceptions of high profile low probability risks that lead to calls for state intervention and low profile high probability risks that are seemingly accepted without concern. Douglas (1985) had earlier noted that the attention given to some risks over others is culturally embedded. She suggested that “public moral judgments powerfully advertise certain risks” and that “well advertised risks tend to be associated with legitimating moral principles” (Douglas 1985:60).

The ways in which categories are invoked and applied to individuals and groups as a consequence for moral order and social control have been a concern for the sociology of deviance (Lemert 1972). Labelling behaviours are at their heart transactions between people and reflect a wider un-spoken social order. When rules are enforced within society the consequence is that rule breakers are liable to be labelled deviant (Becker 1963). Labelling is one way in which the wider social group protects itself against what may be regarded as social problems. Social problems, argued Lemert
(1972) are part of a climate of opinion within communities which anticipate social control needs. Forensic mental hospitals provide one part of the means for effective social control of mentally disordered offenders. Social control mechanisms also extend far beyond the walls of forensic mental hospitals. Leaving forensic mental hospitals to return to community living is a highly scrutinised process in which the person effectively remains available for monitoring within the wider medico-judicial system. This continued surveillance has been conceptualised as a form of transcarcerative social control (Lowman, et al, 1987).

A transcarcerative approach is a response to the social problem presented by risk behaviours of people who are seen as unpredictable and, by virtue of their previous actions, dangerous. The predictive accuracy of harm to others is fraught with problems such that even the best actuarial tools perform substantially below that which is commonly acceptable in other branches of medicine (Swanson, 2008). However as Langan (2010) cogently argues much risk assessment practice is only concerned with risks for which workers will be held accountable. This focus on accountability excludes a broader consideration of risks to risky individuals including those occurring as a result of contact with services. Moreover it seems that there is a danger of positioning people with mental illness as solely risk makers. This may be particularly so in forensic services where past behaviours retain considerable power in the present.

Iatrogenic risks, meaning those linked with the provision of care, are infrequently considered in the delivery of mental health services. The most obvious and perhaps most frequently cited iatrogenic risks are those posed by psychotropic medicine such as irreversible side-effects (Busfield, 2004; Whitaker, 2004). Kelly and McKenna,
(2004) further noted that risks associated with discharge from hospital also include those presented by the community itself in the form of discrimination, stigma and possible physical attack.

Risk in mental illness is often presented from the perspective of professional workers without reference to alternative views that may be available. This ‘professional’ perspective also permeates the face-to-face practice of risk work leading Langan (2008) to conclude that individuals were often unaware that a risk assessment had taken place. The phenomenon of risk however suggests that there are competing bodies of knowledge (Lupton, 1999) about the concept itself. Risk is a socially constructed concept that is positioned by much of the mental health literature as a binary opposition between the rationalist professional view and non-professional versions. Lupton (1999:56-57) notes that “risk perspectives of experts are privileged as objective and factual over those of lay people” whose perceptions are found wanting and contaminated by cultural influences. Professional perspectives are somehow seen as immune from these very same influences. This rationalist technical perspective however provides a one dimensional view of notions of risk. Wynne (1996) goes further and questions assumptions in the wider risk literature about what knowledge counts. These assumptions essentially reproduce dichotomies such as expert versus lay knowledge and thus delimit our understanding of the sense of risk. One alternative is to use a multiple perspectives approach that allows lay and professional accounts to stand side by side as credible versions of the day-to-day realities of living risky lives.
The study

This research was conducted with patients and staff contacted through two National Health Service settings. These provided forensic mental health inpatient and aftercare services in a large geographical region of the UK consisting of both large urban areas and sparsely populated rural areas. The settings provided for both the preparatory stages of discharge and aftercare monitoring and supervision.

The approach in this study has been to examine everyday understandings in accounts offered by discharged patients and workers involved in aftercare monitoring. A multiple perspectives approach in which both worker and service user accounts are analysed can provide the opportunity to examine the differing views and separate stances of a vulnerable group and those working with them. In treating talk as action-oriented, and therefore functional, this study approached verbal communication as constitutive of social action. Talk is seen as a means for accomplishing socially relevant actions. The study adopted an ethnomethodological stance of seeking to explore people’s own displays of their understandings of life events, as produced in talk. The context for this interview talk was one of discharge and return to community living. In-depth interviews were used to facilitate participants’ accounts of discharge. The intention was to focus not only on what “really happened” but also on the situated talk that illustrates the social organisation of everyday life as evident in the utterances of actors (Edwards and Potter 1992:57). Approval for this study was gained from two Local Research Ethics Committees in the relevant geographical areas. All participants provided informed written consent, were free to withdraw and were assured of anonymity and confidentiality. All participant names used here are therefore pseudonyms and an indication of the amount of time on conditional
discharge is provided in brackets at the end of each abstract for context. A fuller discussion of the ethical issues is provided elsewhere (Coffey 2008)

**Approach**

The study consisted of twenty-two in-depth interviews with twenty service-users, nineteen interviews with their social supervisors (n=10) and eighteen interviews with community psychiatric nurses (CPNs) (n=10). Social supervisors were at this time social workers with responsibility for reporting to the Ministry of Justice on the progress of the patient in the community. A further nine conditionally discharged patients approached for this study declined to participate. All patient participants were resident in urban areas at the time of the study in part due to the direction of the supervising teams. Interviews ranged in length from the shortest at twenty-five minutes with a nurse participant to the longest at over two hours with a service-user participant. Patient participants were recruited through information sheets passed to them by workers. Interviews with patients took place first and then workers were approached to participate. This total of fifty-nine interviews formed the material for analysis. The approach was to allow participants to prioritise what they wished to in their accounts of discharge and follow-up aftercare. Interviews were recorded for later transcription and took place in the person’s home or for workers, in their places of work.

**Data Analysis**

All recordings were transcribed with the aim of examining accounts and the work that these were used to accomplish. The transcribed research interviews amounted to over 350,000 words in fifty-nine separate documents. Transcripts were coded followed the
process identified by Braun and Clarke (2006) to produce a detailed and exhaustive category system of issues raised in each interview and to link interviews and categories together. The focus of analysis then moved to consider the sequential organisation of talk and the discursive actions which accounts worked to achieve (Edwards and Potter, 1992). This approach is concerned with examining people’s practices such as communication, interaction and argument. Narratives provided by participants in research interviews allow actors to account for both their view of themselves, and the social world around them (Scott and Lyman 1968). This approach recognises that accounts function to achieve particular rhetorical ends in that they persuade, argue, convince and show awareness of competing versions (Radley and Billig, 1996). Edwards and Potter (1992) argue that a discursive action approach positions language as representation subordinate to language as action. The focus of analysis was on what purposes talk was put to by speakers themselves. Additionally a focus on multiple perspectives may highlight discrepancies between worker and patient accounts and signal problems in agreements about treatment goals (Anderson et al. 1989). The approach was to examine accounts provided by actors and in doing so it was possible to see the self-interested ways in which these utterances operated (Edwards 2006).

This paper reports on one aspect of the analysis of these data, namely the ways in which talk about deviance was handled within the context of aftercare monitoring. The analysis will show that service-user participants signalled the twin concerns that intensive aftercare arrangements exposed them to greater risk of recall to hospital (and therefore further prolonged detention) and that it also effectively revealed their deviant status to the wider communities in which they lived. This analysis suggests
that in providing intensive aftercare focusing on particular types of risk behaviours workers contribute knowingly in the form of decisions to recall the person and unwittingly through their presence in locales, to increasing the risk of failed community integration.

**Analysis of findings**

Risk remained an ever-present concern in accounts of leaving hospital provided by workers and individuals receiving aftercare. In workers’ accounts the discharged patient was positioned as a risk maker. This positioning functioned as a warrant for overtly intrusive aftercare and sometimes surreptitious information gathering.

Patients’ accounts positioned their risk making as historical and temporary and worked to highlight other concerns such as those associated with deviant labels.

The legislative power provided by Section 41 restriction implicates a range of risk management technologies to monitor and if necessary prevent particular activities. Monitoring of the individual was reported by participants to include the collection of non-routine urine, blood and hair samples to determine ingestion of illegal substances where these were implicated in risk behaviours. Some participants also reported being breathalysed to detect alcohol intoxication. Mental state examination and risk assessment were conducted by interview at each meeting with workers, which often took place weekly. Monitoring was often extended through the use of supported accommodation and daytime activity placements provided by voluntary organisations. Here the onus was placed on housing and day-care workers to reliably report to the clinical team aspects of the person’s behaviour, sleep, mental state and daily living skills. For workers the movement from highly supported settings to independent
living had to be “a risk worth taking” (social worker participant). These surveillance arrangements were therefore seen as essential in the management of future possible risk behaviours.

For some participants, curfews were imposed to restrict movements outside of the placement during night-time hours. The requirements of aftercare also included an insistence by the clinical teams that service-users disclose their offences to new intimate partners or prospective employers. The effect of disclosing the offence in a job interview limited reintegration attempts for one participant.

I: So eventually you were on a section 37/41
P: That’s right yeah I got that order in the end yeah
I: So what did that mean to you then?
P: I didn’t like it at first because of all what’s happening now with people coming to see you and being restricted and things like that.
I: You said you didn’t like it at first
P: No I just got to accept it in the end. (3) You know the length of time I was in the [forensic hospital] I just got to you know really accept it. (2) If it was getting out of there you know it was way of getting out of there you know and that was it like, go along with it. (2) What I find now, now I am out is the restrictions on me if I go for a job and things like that they want me to disclose my offence and things like that which I find puts the employer off and (1) you know.

[Colum: 9 months]

Colum indicated twin concerns associated with aftercare monitoring. These were the regular visits he received from workers and police and the conditions he was required to follow. In this extract Colum suggested that these were agreements that he had to “go along with” for the purposes of achieving discharge. However these conditions themselves presented challenges for integrating back into his community. It appeared that agreements made in secure settings about future community living and without full knowledge of the likely outcomes had presented unexpected challenges to the work of fitting-in for patients. Colum’s understanding was that disclosure of past events for risk management reasons negatively affected his prospects of employment.
The requirement of disclosure may run the parallel risk of prolonged unemployment and continued exclusion for Colum and others in the same situation. The possibility of exclusion may be “a risk worth taking” for those providing aftercare but it remains a problem for patients themselves. Interestingly Colum’s social worker constructed the need for disclosure as an opportunity for him to learn and gain positive outcomes.

P:...if we’re right about this we should be encouraging him to do this for himself. If he can do that for himself, go in, deal with the disclosure, have his own interview, he’ll get more self-esteem from that, he’ll feel good about himself.

[Colum’s social worker]

This attempt to turn on its head the caution about revealing oneself to others with a claim that therapeutic gain may be possible appears to downplay the concerns expressed by Colum and the very real consequences that might arise from disclosure.

The volume and frequency of domiciliary visits by workers among others was summed up neatly by Brendan as “the big follow-up” and a wider sense of being constantly under the scrutiny of these teams appeared in most accounts.

P: I get a couple of visits a week you know, [social worker], phone rings for the one, I see [CPN] on Monday. I bumped into her yesterday as it was and like she was supposed to phone you know but as it happened I was in town. I asked her, she was going to phone at 11 o’clock you know. The big follow-up you know and I can understand it you see. I see [CPN] every Monday, every month then I see a psychiatrist and I see [social worker] on a Thursday. So you got 2 visits a week.

[Brendan: 3 years]

Participants on conditional discharge had a sense then that they were someone who had “got to be kept an eye on” (John: 1 year) by multiple community agencies charged with this task. The worry for John was that should his volatile relationship with his current partner result in a fight then this would have significant consequences for him.

P: Yeah I know, but it’s not too bad, but it does, when we have a fight I don’t like that cause if I hurt him, he goes to the police, I get, they’ll put me in hospital. The police will look at me and say we’d better get him off the streets. When I’m a couple of weeks in, when the full story was told, they’ll probably you know, going to the police station say and me from [high security hospital] wop straight away, they’d send a van you know,
but [local area] police know me well now. They know about me because they have a meeting don’t they a MAPP (sic) meeting? (clarifies MAPPA refers to multi-agency public protection arrangements)Every so often I’m in the meeting because I’m on their patch so you know they come in now and again to see if I’m alright they said. I couldn’t believe that. They said yeah we pop round, they said we haven’t just forgot, we’re not going to have a meeting and just forget about you cause you have got to be kept an eye on.

[John: 1 year]

John refers here to additional formal inter-agency meetings to discuss monitoring of the individual in the community. These meetings are part of a statutory framework known as Multi-Agency Public Protection Arrangements (MAPPA), for collaborative working in assessing and managing violent and sexual offenders in England and Wales as set out in the Criminal Justice Act 2003. Police, probation and prisons work together supported by other agencies to manage the risk dangerous offenders may pose to the public. Many participants in this study were subject to these arrangements and frequently received visits from the police as a result. John’s account presented his understanding that his continued liberty remained tentative and subject to interpretations of his behaviour. His concern was that interpretations are always coloured by knowledge of previous behaviours.

The extent that people were actually routinely supervised by workers varied depending on the type of accommodation they were living in, the length of time since discharge and the terms of their conditions. For instance, those living in independent accommodation were visited at most once or twice a week while two participants were required to be in the company of a housing support worker at all times. Workers in housing placements, carers, friends, employers and family members were also recruited to provide information to the supervising teams. The perception of control implied in such close supervision was summed up by one service-user who alluded to
being like a puppet.

P: Yeah I think I’ve handled things very well, yeah but all that old red tape nonsense like but um, they’ll be getting some strings next and dangling me on strings (3) you know that’s what they’ll be doing next. [Dave: 3 months]

Continued supervision in the form of aftercare was described by service-users as like “living under a microscope” (Keith: 3 years), and “more intrusive and restrictive than ever before” (Tim: 3 months). Its purpose was to facilitate swift recall to hospital in the event of increased risk behaviours or deterioration in mental health. Participants who had been discharged the longest expressed greater dissatisfaction and concern with the continued nature of aftercare monitoring. In many ways these participants had more to lose by the threat of recall to hospital. Perhaps too they had less need of the ease of access to treatment and inpatient care that was a feature of accounts that stressed the benefits of conditional discharge.

One unforeseen outcome of aftercare is the potential it offers to single out and identify individuals to the communities in which they reside. In the next section an analysis of accounts is presented which suggests that aftercare itself highlights deviance and contributes to the community rejection of conditionally discharged patients.

Aftercare and the threat of deviance labels

Deviant labels remained a continuing concern for participants as they sought to settle into new communities. In particular it was noted that the weight of past events made these labels particularly sticky.

P: What you’ve done in the past sticks with you all the time, you know um. I’m still classed as a dangerous person cause if I wasn’t dangerous I wouldn’t have anybody with me would I? So it just shows along that way that people still don’t trust me like.
In this extract Dave highlighted his concern that deviance is still a current concern for workers as evidenced by the terms of his discharge order. Dave was required to be in the presence of a worker at all times when he left his supported accommodation. Dave displayed his understanding that this implied a concern on the part of workers that he was not to be trusted. The phrasing “I’m still classed” worked to indicate that an external authority was responsible for this designation and it was one that Dave rejected in his next turn.

I: Do you see yourself as being dangerous?
P: No I’m not dangerous but like I said though, it’s like talking to the brick wall isn’t it; I can’t get no sense into anybody.

Externalising the designation to a faceless or even omnipotent source did the moral work of placing Dave as the victim of the system of care and control. The community psychiatric nurse’s (CPN) account however implied that concerns about risk behaviours had guided determinations of which conditions should be included in the discharge order.

P: I suppose he is quite unusual given the sort of the care package that had been put together, umm given the fact that he doesn’t or he is not allowed to go anywhere on his own. Umm he is supervised 24 hours a day whether that’s in the house or you know out in the community as well. Umm and I suppose as his CPN you feel a bit more relaxed about things because umm you are not worrying too much about where he is and what he is doing. It’s not like somebody that you would visit say once a week and maybe for a maximum of 2 hours and then they are left to their own devices for the rest of the time as is with the majority of my other clients on my caseload.

As Annandale (1996) has noted, concerns about risk may be based on historical events but determinations also consider possible future negative outcomes. The CPN’s account displayed a concern that workers were required to know where Dave was at all times under the conditions of his discharge. These conditions were
unusual and reflected an anxiety that Dave remained an individual who was viewed as risky. The worry about his past offending placed a significant responsibility upon workers in relation to possible future behaviours. This unease was made relevant in the CPN’s account where he highlighted the unusual nature of the arrangements and his reference to “the sort of care package that had been put together”. The CPN was highlighting that the care package was not the standard type in aftercare arrangements and he followed this utterance by indicating precisely what was “quite unusual” about it. Despite a little uncertainty (“Umm and I suppose”) the CPN concluded that these arrangements provided workers with some reassurance about the activities of the individual. The background expectation that future risks must be managed perhaps unsurprisingly has led in this example to a “care package” designed to constantly monitor an individual seen as particularly risky.

In some cases worker accounts can be read as showing a concern to balance the likelihood of significant risk with the likely effects of this level of supervision upon the person and their attempts at trying to fit into social settings. Inevitably perhaps the balance was weighted towards preventing future high profile dangerous acts towards others. Dave’s social worker, for example, indicated that difficulties in achieving integration were a price that was necessary for community placement for someone deemed risky.

P: I suppose in terms of Dave making friends you know externally it’s, it is actually quite limited for him because of this requirement of (3) you know having to be supervised all the time.

     [Dave’s Social Worker]

It can then be seen that “a risk worth taking” was also one in which the person was willing to co-operate with requirements for ongoing monitoring beyond the walls of
the institution. However as can be seen in Dave’s account this co-operation did not extend to agreeing with the risk designations of workers.

The concerns expressed by service users with regard to handling deviant labels may be related to social sensitivity (Lee, 1993). Sensitivities surrounding certain types of information have implications for the individual in that they imply risk or threat to identity (Sieber and Stanley, 1988). As such concealing or keeping hidden those aspects germane to identity in mental illness and criminal offending is a tactical move by actors which may be seen to help with social bonding. Hiding the relevance of particular social identities from others can be difficult in the face of intensive aftercare by the clinical team. In the following extracts participants Bill and Tony expressed this concern. It was perhaps particularly relevant for them as they had recently returned to live in their communities. Bill provided an understanding of problems associated with visits of workers to his home while Tony was concerned with preserving his anonymity and avoiding the label “murderer”. They articulated concerns that background information about them would become known to others.

P: … the other neighbours I didn’t really get on with (2) for some reason.
(2) They may, see when you’ve been discharged from hospital on a 117 you get people coming to your house with briefcases and doctors and nurses and all that sort of thing, it looks a bit funny you know. (4) It doesn’t matter here so much (17).
I: So you [think]
P: Very stigmatising] it is you know …. 

[Bill: 6 months]

P:…. But I wonder is it worth; well I wonder what these people think me living here on my own sort of thing.
I: Your neighbours?
P: Yeah, well they see people coming back and forth like [CPN] and (2). I haven’t got a problem with it mind, they can think what they like really. Mind if they do know I can’t do anything, I can’t change it, (2) I can’t
Bill was referring to his decision to relinquish a previous tenancy. He constructed this decision as being the result of problems with his neighbours, “but things got too difficult for me there”. This utterance implicated external causes as responsible for the problems encountered in maintaining independent living. Bill’s account was sequentially structured to present the problem of not getting on with his neighbours followed by an explanation in the form of visits from workers. The provision of a ready explanation had significant rhetorical power, making the account both plausible and convincing.

Bill’s account made use of commonly available knowledge about people with mental illness and the likely negative effects of their illness-related behaviours. From Bill’s account it was not his demeanour, his behaviours or his symptoms that identified him as mentally-ill but rather the stigmatising consequence of workers visiting him at home. The frequent visits by workers and statutory services in effect unmasked him to the local population. These visits caused him a certain amount of social embarrassment. Bill’s account does the work here of loosening claims that his problems arise out of embodied mental illness and result instead from the labelling activities of others (Rosenhan, 1973).

Concerns about stigma and discrimination in mental illness have focused upon the presentation of self and the subsequent labelling behaviours of actors within social systems (Lemert 1962; Goffman, 1963; Scheff, 1966:84; Link et al, 1989). Mental illness and dangerousness are both powerful labels. Bill’s account worked to
construct an alternative moral concern that he suffered material disadvantage by his association with mental health services. This is a difficult position to sustain given that this client group have for the most part demonstrated serious risk behaviours that warrant the use of ongoing monitoring and surveillance. It is however a view that is taken up by other speakers in their accounts and one which though seldom heard is nevertheless valid. The recurring problem for people with mental illness is that any account they offer can be easily dismissed or downgraded with reference to their condition. An example of this was evident in the account of the CPN when discussing Bill’s concerns about social integration.

P: Where he was living in the past was a flat in a block of flats umm, …. He had delusionary ideas about people above him, people on the left and the right of him and there were others in the block who had mental health issues as well. …..So you have a group of people who had mental health issues in one block in one area and the local population would tend to shun them there’s no doubt about that. So these ideas that he is being shunned or being pointed out or being talked about (2) are probably emphasising reality going on as well.

[Bill’s CPN]

The CPN here used the mental illness label as a lens through which Bill’s concerns could be interpreted. However, he did acknowledge that these concerns may be legitimate but nevertheless insufficient to trump worker’s priorities.

Tony shared similar background expectancies with Bill in regard to how others might respond to him. He wished to preserve his anonymity as a means of easing his way into a new social setting. Tony’s account indicated that both he and his neighbours accessed everyday knowledge about people who require regular visits from statutory services. In other words, people who are visited at home by workers must be in need of special supervision and are therefore liable to be categorised as someone to be cautious about. Both Tony and Bill accessed this culturally available knowledge as a
way of explaining concerns with establishing social bonds in their communities. Workers on the whole were not indifferent to these concerns as Tony’s CPN acknowledged.

P:….. I think he has struggled because he is trying to get away from the index offence and people who know him and know of that really. …. But umm, he struggles with more of a fear I think of other people recognising him and that’s why he tends to…. he tends to keep away from his past life really and that stops him integrating as well.

[Tony’s CPN]

Tony’s CPN noted that he feared the social consequences of being known for his previous behaviours and wished to maintain his anonymity. Like other workers interviewed for this study she appeared unaware of the possibility that the frequency of worker visits may be a factor in unmasking him to his neighbours. Service user concerns about negative labelling from communities may lead them to withdraw and disengage from others within the social system. This isolation can be a problem for the individual if we accept that engagement is itself a positive and contributory part of building social capital.

These accounts highlight the identity challenges that are part of living with mental illness in contemporary settings (Estroff, 1989). While attempting to live independently Bill and Tony had to sustain their identities as competent adults capable of managing their own homes, a view that was challenged by repeated hospitalisations or the requirement for visits by statutory services. The accounts demonstrate that discharged individuals were keenly aware of the negative identity labels available, and assignable, to social behaviours that can be categorised as mental illness.
Discussion

Conditionally discharged forensic patients as a group are in a highly liminal position. In a very real sense they are “betwixt and between”, positioned as outsiders but attempting to reintegrate into communities (Turner 1969:95). They may not benefit however from the shift towards more benign views among the general public regarding mental illness (National Statistics, 2011). This is because forensic patients embody concerns of dangerous and chaotic mental illnesses in a way which people with more common conditions such as depression do not (Dallaire et al, 2000; Angermeyer, & Matschinger, 2003). The reintegration of this group into communities presents a social problem implicating the need for social control measures in the form of continued monitoring and surveillance.

Direct powers to access the person for assessment, intervene in social interaction by limiting specific social contacts, compel treatment and if necessary return the person to hospital, offered workers and service-users alike clear social control imperatives. However, these powers are a short term measure that may not be sufficient to support continued community tenure once the order is eventually terminated. Langan (2010) has noted, for instance, that risk assessment practices in mental health often overplay individual factors at the expense of structural, social and interactional causes. The alternative is to develop opportunities for individuals to benefit from social bonding, adjustment and integration with the aim of making community tenure more sustainable in the absence of overt measures of social control such as ongoing intrusive monitoring. Grusky et al (1985:50) argue that;
“…the reintegration of this “deviant” population into the community can be understood by applying social system concepts of social bonding, social status, and social adjustment”.

It has also been suggested that social capital is an effective means to social control because investment in relationships requires a degree of conformity to established norms (Portes, 1998). The concept of social capital is a possible explanatory and functional model to address the range of challenges faced by people with mental illness living outside of hospital within communities. The concept addresses both micro-level (individuals, family, household, community) and macro-level (statutory, voluntary organisations locally, nationally and internationally) aspects of community cohesion. Central to the notion of social capital is the requirement for people to have reciprocal trusting relationships with others that help form and bolster individual and collective identities. Many patients who participated in this study expressed fears that deviant labels made it difficult to establish new relationships and reflect other findings that discharged people remain isolated within communities (Gerber et al, 2003). Enabling reciprocal supportive relationships outside of deviant identities is therefore an ongoing challenge for workers and one which should be given more emphasis.

Exclusion from social settings may jeopardise opportunities to benefit from available social capital, reducing the possibility of social control and endangering community tenure (Kelly, 2005). Another possibility is that conditionally discharged individuals may be at increased risk of re-offending in part as a response to the stress produced by social isolation. Indeed participants (such as Tony) who avoided previous identities and locales in attempts to reduce stigma or criminogenic influences may run the additional consequence of reduced access to positive social capital. It is worth noting however that a cautious note on the relevance of social capital to mental health has
been sounded (Henderson and Whiteford 2003). There are additional reasons to be cautious given that available social capital may be lower in modern societies where inequalities between the rich and poor are marked (Wilkinson and Pickett, 2010). Inequalities based on gender, race, creed and social class may also be embedded in what Farmer (1999:1488) refers to as “structural violence”. Structural violence is the negative combination of social, economic and political factors upon the health and well-being of social actors which can place community re-integration attempts in jeopardy.

Workers who participated in this study downplayed re-integration attempts as part of their work. Instead issues of public protection, risk assessment and establishing extended forms of monitoring were emphasised in their accounts. This is not to say that workers were unconcerned about intrusive practices. However few qualms were expressed by workers about the level of monitoring and surveillance. They instead constructed their work as necessary for public protection and an important means to an end. This reification of public protection appeared to reach its apotheosis in the requirement for conditionally discharged individuals to disclose to potential new employers or intimate partners their previous risk behaviours. Service user participants remained unconvinced by the claim of positive therapeutic outcomes of such disclosure. This is perhaps not surprising as they were living daily with the consequences of previous risk behaviours and feared that further disclosure would cement in place these disadvantages.

Workers often drew on previously demonstrated risk behaviours as a ready explanatory resource for the imperative to stay closely involved. These workers
operate in a system in which multiple previous inquiries have functioned to apportion blame for untoward events. The somewhat softer concerns about risks to social inclusion caused by their visits may therefore have limited currency in these circumstances. Nevertheless there remain significant iatrogenic effects for the patient. The possibility of swift removal and return to hospital creates apprehension among patients that their living arrangements are always tentative and subject to changes that are outside of their control. Workers may be satisfied that recall to hospital protects the public but for the patient this mechanism threatens relationships slowly built up since discharge and places tenancy and employment in jeopardy. The possibility of community reintegration may quickly be lost and relationships between workers and patients can become strained. For workers “a risk worth taking” was one where they could ensure a steady flow of information on the progress and behaviours of the conditionally discharged individual. This required arrangements to be made prior to discharge to enable the safe management and early detection of untoward behaviours.

Forensic services effectively act in ways akin to a risk escalator. A risk escalator is defined as

“a system, designed or emergent, which is oriented towards managing a defined health risk, and which is made up of a set of sub-systems, ordered in terms of different trade-offs between autonomy and safety, through which service-users may move”

(Heyman, 2005:44).

To operate as a risk escalator a system must be able to differentiate between steps in treatment relative to assessed risk, attempt congruence between the safety/autonomy balance in relation to assessed risk and have the potential to move people towards greater autonomy or safety dependent upon these assessments.
(Heyman et al 2004:310). Traditionally the assessment and management of risk behaviours has been conducted behind the walls of large institutions but contemporary moves toward community care have introduced new challenges of providing assessment, support and treatment in an arena that is open to much more public and professional scrutiny. This new arena opens the way for judgements to be made about the practices of workers and allows the apportioning of blame when untoward events occur (Douglas, 1992). Workers are therefore attuned to the dangers of wrong decisions about risk of harm to others. Participants in this study shared background expectancies that remaining well for a sustained period in the absence of risk behaviours was a means to move further down (and potentially off) the escalator. Patients presented this within a temporal dimension going as far as stipulating a specific number of years over which recovery and non-risky identities could be established. Workers for their part while acknowledging these benchmarks were far less optimistic about the possibility that patients could step-off the risk escalator. This then raises a further concern about what happens when patients realise they are effectively stuck with ongoing monitoring with no opportunity to end their contact with services.

The accounts of participants can be read as concerns with impression management (Goffman 1959) in which the current risks of fitting in are prioritised by service users over the historically-informed concerns of workers. Service users’ displays of understanding about their social situations can be likened to Turner’s (1969) notion of threshold people in which identities not fully formed are constantly worked, re-worked and rehearsed in multiple settings as part of the ongoing process of establishing community reintegration. Workers constructions of risk as current
function as threats to the development of new ordinary identities and appear from the perspective of the individual to downplay everyday risks. Both sets of concerns are nevertheless real and action taken to address one set of dangers may necessarily invoke another set of dangers. The selection of which dangers to focus on by each group can then be read as being social organised and for self-maintaining purposes (Douglas, 1992). To the extent that workers are supported by the legislative and moral power of protecting the public it is perhaps inevitable that these concerns dominate.

Service-users held what sometimes appeared to be contrasting sets of views about the level of aftercare monitoring. In a number of cases participants indicated that conditional discharge was preferable to continued detention. They indicated that they valued the benefits aftercare afforded in terms of regular supportive visits and guaranteed access to inpatient treatment which many had failed previously to secure. There was general (if at times reluctant) acceptance of the need to comply with treatment and abstain from both legal and illegal substances. However over time the continued support was perceived to suffocate and restrict opportunities for fuller participation in their communities. Participant accounts do the moral work of accomplishing a shift from risk objects to risk subjects. Rather than presenting risks they themselves are now at risk through the work of others. This constructs patients as victims of a system of care intent on intrusive monitoring despite possible negative consequences.

Conditional discharge affords greater liberty to individuals than detention in hospital but it still remains a modest freedom. It is a freedom limited by numerous
contingencies some of which may be read as maintenance of risk escalators or overt attempts at social control. The greater liberty offered alters the level of social control provided by hospital detention and shifts the locus to the community setting where it is extended by use of proxy agents in the form of non-statutory groups such as housing organisations. Social control of conditionally-discharged people is therefore pervasive and subtly applied. The freedoms that conditional discharge offered were constructed by workers as limited, restricted or conditional for the sake of public protection. Workers understandings were that any changes in monitoring brought about by living arrangements had to be a “risk worth taking”.

**Conclusion**

In everyday social interaction, forensic patients resist attributions of mental illness or criminal offender labels in an attempt to establish ordinary rights to community membership. Conditional discharge in effect delays the return of ordinary rights and prolongs monitoring and supervision, ostensibly to re-establish the person within the wider social setting. Workers show that while they are aware of the intrusive nature of their monitoring they remained convinced that this was the best way of managing potential risk behaviours and avoiding blame. The belief that this intensive supervision provides sufficient leverage over individuals to reduce risk behaviours in the absence of attention to social and structural factors may however prove unfounded (Swanson, 2008).

The current study indicated that forms of social support post-discharge for service-users were limited and offered little in the way of sustained efforts at integration back into the communities from which they had originated. Workers prioritised public
protection in their accounts as the dominant focus of their work. Participants indicated that aftercare in the form of prolonged surveillance contributed to labelling, discrimination and stigma. The concern expressed by many service user participants was that intensive support and surveillance increased risk of rejection and isolation by the communities in which individuals hoped to reside.

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References


TRANSCRIBING CONVENTIONS

[?????] inaudible word or passage of speech
[drinks coffee] description of participant action during research interview
over[lap] square brackets between adjacent lines indicate beginning and end of hear-able overlapping talk
underlined underlined words or part of words denote emphasis placed by the speaker
(1) timed pauses to the nearest complete second
Uh or umm Sounds uttered by participants in the course of their speech
..... Omission of a part of the transcript
wor- Use of a hyphen appended to an incomplete word indicates a sharp cut-off of the word or sound
I: Denotes interviewer
P: Denotes participant