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**Accomplishing being ordinary: identity talk of people
conditionally-discharged from secure forensic settings**

Thesis submitted to the University of Wales in fulfilment of the
requirements for the
Degree of Doctor of Philosophy

By

Michael Coffey

School of Health Science
Swansea University
2008

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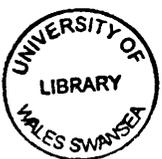
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SUMMARY

This study examines the stories of offenders discharged from forensic psychiatry facilities and currently being supported by professional workers in the community. Through the use of in-depth interviews with conditionally-discharged persons, community mental health nurses and social workers, the process of discharge and reintegration was investigated. Analysis of audio-recorded and transcribed talk focused upon the action-oriented nature of accounts related to the experience of discharge and community return, and the attempts of former in-patients to construct viable identities in the outside world.

Interview talk is used by social actors for self-interested purposes. Talk in interaction works to accomplish more than accounts of events past, it also achieves identity orientations. Labels signifying mental illness and criminality can present enduring identity-threats to people leaving forensic in-patient settings. As they adjust to return to the community, individuals deploy particular types of identity talk to neutralise ascriptions of continuing deviant identity and make claims to normality. They face special challenges in accounting for past behaviours, while also laying claim to normal lives. It was found that notions of past sickness were often used to mitigate responsibility and counter inferences of continuing criminality. Service users made reference to commonsense understandings of recovery to distance themselves from the behaviours and situations that had led to detention. Displays of ordinariness were worked-up in talk through multiple stages that involved establishing the credibility and authenticity of accounts, creating distance and difference from others with similar labels and claiming normative roles. They constructed new identities that worked to resist dominant professional discourses but nevertheless were resolutely mundane. In their day-to-day lives the accomplishment of 'ordinary' identities was a continuing and necessary task in securing successful community return.

DECLARATION

This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

Signed..... (candidate)

Date 12/2/09

STATEMENT 1

This thesis is the result of my own investigations, except where otherwise stated.

Other sources are acknowledged by footnotes giving explicit references. A bibliography is appended.

Signed ... (candidate)

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STATEMENT 2

I hereby give consent for my thesis, if accepted, to be available for photocopying and for inter-library loan, and for the title and summary to be made available to outside organisations.

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In completing this thesis I am indebted to the people using the services, and the workers, in the two settings where I conducted data collection. It perhaps goes without saying that without their willingness to talk of their experiences I would have been unable to complete this study. I am very grateful to them.

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GLOSSARY OF TERMS AND ABBREVIATIONS

Aftercare	Aftercare is a term commonly used in the talk of participants to refer to the provision of services to conditionally-discharged people following their return to the community.
ASW	Approved Social Worker – An Approved Social Worker is social worker specifically trained to assess a person's needs for care and treatment under the Mental Health Act 1983. They are appointed by local authorities in England and Wales for the purposes of determining social care needs and suitability for compulsory treatment in hospital or community settings.
CPA	Care Programme Approach- This is a system of care co-ordination and management introduced in 1991 into England, and latterly in 2005 in Wales, which requires health and social care providers to liaise to assess, and plan to meet, the identified needs of people in contact with specialist mental health services. Key components of this system include the provision of an identified key-worker, a plan of care and regular reviews by the mental health team.
Conditional discharge	Conditional discharge is shorthand for discharge from hospital subject to conditions as allowed under Section 41 of the Mental Health Act 1983. This part of the Act is also referred to as a restriction order. The significant condition is the power retained by RMO and the Home Office to recall the person to hospital should it be deemed necessary for the protection of the person or the public.
CMHN	Community Mental Health Nurse – As above. The substitution of the words 'mental health' for the word 'psychiatric' has been seen by some parts of the profession as a more positive focus on health rather than illness.
CPN	Community Psychiatric Nurse – This is a registered mental health nurse responsible for the assessment, planning and delivery of care to a caseload of people with mental ill-health living in the community. Many nurses continue to use the abbreviation as a shorthand description of their work although some take issue with the use of the word 'psychiatric' in the title.
Home Office	The Home Office is the government department responsible for public protection arising from crime, terrorism and what are termed anti-social behaviours. Through its Mental Health Unit the Home Office oversees detentions in mental health services which result from convictions in a Crown Court.

Index Offence	This is the term commonly used in forensic mental health services to refer to the criminal offence for which the person was convicted and resulted in the imposition by a Crown Court of the detention and restriction orders under Sections 37/41 of the Mental Health Act 1983.
High Security Hospital	also known as the Special Hospitals— see below
MAPPA	Multi-Agency Public Protection Arrangements - This is a statutory framework for collaborative working in assessing and managing violent and sexual offenders in England and Wales. Police, probation and prisons work together supported by other agencies such as Local Authority housing, Social Services, Health, and Youth Offending Teams to manage the risk dangerous offenders may pose to the public.
MAPPP	Multi-Agency Public Protection Panel - This is a panel comprised of various agencies and brought together under MAPPA framework to manage the "critical few" who are deemed to pose the highest risk of causing serious harm, and require multi-agency co-operation at a senior level.
MARAC	Multi-Agency Risk Assessment Conference - The MARAC is a formal conference to facilitate the risk assessment process and consider any implications for victims in respect of known sex offenders or potentially dangerous offenders. In this context the MARAC may refer on to MAPPP those deemed to pose the highest risk to the public.
MHRT	Mental Health Review Tribunal - Mental Health Review Tribunals are appointed by the Ministry of Justice, are usually chaired by a retired judge and have responsibility of hearing applications and determining suitability of continuing detention of people subject to the Mental Health Act 1983.
Restriction Order	See Section 41 below
RMO	Responsible Medical Officer – This is usually a consultant psychiatrist who has responsibility for the care and treatment of people subject to the Mental Health Act 1983 who reside in hospital or in the community. The RMO has specific reporting responsibilities related to the care of those subject to Sections 37/41 of the Mental Health Act 1983.
RSU	Regional secure unit – sometimes referred to as medium

secure units – RSU's are regional National Health Service units managed locally at NHS Trust level and usually providing services for defined geographical areas. They are facilities with locked doors and high non-scalable perimeter fences to prevent absconding by patients. Regional secure units differ from high security hospitals in that patients are not considered to be a grave and immediate danger to the public should they abscond.

- Section 37** Section 37 of the Mental Health Act 1983 is an order for the detention for the purposes of treatment for a mental disorder imposed by a Crown Court on conviction for a serious criminal offence. The usual means of terminating such an order is by application to a Mental Health Review Tribunal.
- Section 41** A Crown Court may additionally impose Section 41 of the Mental Health Act 1983 if it is considered necessary to protect the public from serious harm. Section 41 (also known as a restriction order) restricts the discharge of the person unless directed by a Mental Health Review Tribunal or the Home Secretary. This Section also allows for conditions to be placed on the discharge of the person including recall to hospital.
- Section 117** Section 117 sets out the statutory aftercare planning arrangements for detained persons designated under the Mental Health Act 1983. The requirement is for discharge to be planned and for the plan of care to be regularly reviewed following discharge. Section 117 arrangements also make available other forms of funding through Local Authorities to pay for accommodation and day care services.
- Social Supervisor** Social Workers and Probation Officers with responsibility to report to the Home Office on the progress in the community of conditionally-discharged individuals
- Special hospital** High security hospitals in the UK are known as Special Hospitals. Traditionally these were managed as Special Hospital Authorities but in recent years they have come under the management of local NHS Trusts. There are three Special Hospitals serving England and Wales. These are based at Ashworth in Liverpool, Rampton in Nottinghamshire and Broadmoor in Berkshire. High security hospitals to all intents and purposes are mental hospitals with security measures of a category A prison. That is, there are multiple levels of high perimeter fences and walls, access and egress is through one central point, search procedures are in place for visitors as is x-ray screening of property and strict limitations are placed on movements between areas of the hospital and movement of patients outside the hospital

compound. Patients admitted to these hospitals are considered to present a grave and immediate danger to the public and require hospital treatment in a setting offering increased security to that available in regional secure units.

TRANSCRIBING CONVENTIONS

Research interviews used as data for this thesis have been transcribed using a minimum of symbols to achieve more readable extracts. I address the issue of transcription more fully in Chapter 3. The transcripts identify overlapping speech, repeated words, hesitations, incomplete words and brief descriptions of actions of participants or other events such as interruptions. I have removed names of places and people and substituted generic terms such as [hospital] in square brackets where the place or person name would have appeared. Many of the transcription conventions that I have employed are commonplace in discourse and conversational analyses although I have used a more simplified style. I have maintained standard spelling and punctuation through-out and have not attempted to represent local pronunciations. Throughout the thesis all data extracts refer to the researcher as MC and respondents as R.

[?????]	inaudible word or passage of speech
[drinks coffee]	description of participant action during research interview
over[lap overlap]	square brackets between adjacent lines indicate beginning and end of hear-able overlapping talk
<u>underlined</u>	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

CHAPTER 1: INTRODUCTION

1.1 INTRODUCTION TO THE THESIS

This thesis is about the accomplishment and deployment of identities in the talk of people leaving forensic mental hospitals. In most cases these individuals have been convicted of serious criminal offences and diagnosed with an enduring mental illness. Many people leaving forensic mental hospitals are subject to formal aftercare arrangements and monitoring, commonly referred to as conditional discharge. These conditions include providing continuing access to workers for the purposes of supervision, monitoring and the provision of aftercare. Full integration in communities is complicated by labels of mental illness and criminal offending. This thesis is concerned with the ways in which people on conditional discharge negotiate and deploy identities through talk within the context of transition towards full community reintegration.

Negative societal reaction in the form of deviance labels, discrimination and stigma are common experiences for many people with enduring mental illnesses. This may be particularly so for those with criminal convictions for serious offences and a diagnosis of mental illness. Returning to communities, following years of detention in isolated forensic hospitals, can present significant challenges for persons trying to achieve social integration. This thesis argues that stories of discharge function to articulate identities which *inter alia* indicate the moral status of the person, establish credibility and accomplish claims to ordinariness as a way of negotiating viable new selves.

In treating talk as action-oriented, and therefore functional, this thesis approaches verbal communication as constitutive of social action. Talk is a means for accomplishing socially relevant actions. The study was approached from an ethnomethodological stance of seeking to explore people's own displays of their understandings of life events, as produced in

talk. Identity, as one such display, is seen as an ongoing accomplishment of social actors in everyday life. It is achieved in interaction with other social actors and remains open to negotiation and revision. To achieve social reintegration following conviction and detention in forensic services, the actor must produce identity displays which are viable. These displays must achieve acceptable accommodations so that the individual can build new social identities as they attempt to live outside of hospital.

1.2 STUDY OBJECTIVES

This study set out to explore the talk of service-users subject to conditional discharge, their family members, and workers supporting them. The focus was on gaining first-hand accounts, in the form of narratives, of the processes of preparation and return to community living. This provided the opportunity to examine talk within the context of conditional discharge from forensic facilities.

The research therefore had a number of aims;

1. To establish what people said about the preparation for discharge from secure mental health services and return to community living on conditional discharge.
2. To examine the work that interview talk was employed to do in stories of returning to community living.
3. To provide an analysis of how service-users accomplished identity claims and transition in their accounts.
4. To examine the talk of family and professional workers as one way of accessing multiple perspectives of the same process.
5. To inform clinical practice, education and research in forensic mental health with particular regard to the preparation and support of people returning to community living.
6. To contribute new knowledge based upon an analysis of first-hand accounts of people leaving forensic hospitals.

7. To fulfil the requirements of, and produce a thesis for a PhD as per University guidance
8. To form the basis of publication, conference presentations and dissemination through presentation of research findings.

A chronology of the research process from registration to completion of this thesis is provided in Appendix 1.

1.3 WHY STUDY IDENTITY WORK IN THE TALK (STORIES) OF PEOPLE ON CONDITIONAL DISCHARGE

Aftercare monitoring imposes a significant degree of scrutiny and surveillance upon individuals. Much of this is overt in the form of visits from workers to monitor progress and risk behaviours. Some of this scrutiny is however more covert, in that there are expectations that housing workers and voluntary staff in day services will pass on information to the aftercare team. Aftercare effectively works to sustain a transcarcerative system of social control. This is a system in which participants are corralled into one form of surveillance or another (Lowman et al, 1987a). This is an area of social life which may lend itself to sociological analysis of the various structures that enable and sustain these systems of control (Mason and Mercer, 1999). My interest however is in how social actors subject to this aftercare, achieve community return and integration. They must achieve successful reintegration within the context of significant, often intrusive, scrutiny of their daily lives. These forms of scrutiny are rarely studied from the perspectives of those involved. As such, we know relatively little about everyday understandings of people in these situations. There is no current literature examining how social actors achieve (through talk) new forms of social identities that enable social reintegration. There may be limits placed on the range of new identities which can be achieved while living under various forms of covert and overt surveillance. This study is an attempt to address this gap in the literature.

Achieving successful community tenure¹ 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). For people leaving forensic mental hospitals, these challenges are exacerbated by long periods of detention in remote institutions. Prolonged detention and long distances from home, increase social isolation and disconnect people from their social support networks. Leaving hospital can be a time of increased anxiety. The person may have to re-establish contact with family and friends and create new social networks. In new social situations they may be called to account for deviance labels, offences and their enforced absence. They must do this while under the care and monitoring of aftercare teams, police and social services. This level of scrutiny is seen by workers as necessary to manage the potential risk posed by the person and to ensure their swift return to hospital should this be deemed necessary. Based upon limited current evidence it is difficult to assess how recipients of this control view the conditions of their discharge, to what degree they experience these as helpful and what they themselves must do to secure and sustain community tenure.

Most studies in this area of mental health service delivery focus on recidivism and recurrence of risk behaviours in the form of untoward violent events (Gibbens and Robertson, 1983; Quinsey et al, 1996; Wood 2007).

Illuminative as these studies undoubtedly are, there is no attempt to provide a picture of the lives of people following discharge, the work they do to integrate or the difficulties encountered on community return. For example, we know little of their attempts to secure social support. More generally we know nothing of how people deploy and manage their identities within communities where mental illness and criminal offending can lead to experiences of discrimination and isolation.

¹ Community tenure is a phrase synonymous with an approach to community-based mental health service delivery developed by Stein and Test (1980). This involved support to secure successful community-based living for people previously institutionalised in mental hospitals.

Mentally-ill offenders in prison populations experience disproportionate responses in relation to length of sentence, consideration for parole and ongoing surveillance following release, when compared with other offenders who have committed similar offences (Porporino and Motiuk, 1995). These findings suggest that, for those leaving forensic mental hospitals, there remain significant hurdles to be overcome in the form of the discriminatory responses of others.

Mental health services have widely adopted the language of the recovery movement, seemingly in an attempt to orient services toward recovery-seeking behaviours of those with long-term mental illnesses (Jacobson and Curtis, 2000; Liberman and Kopelowicz, 2002). People leaving forensic mental health services may be engaged in similar tasks as they negotiate recovery from their condition. In doing so, one imagines, actors must begin to address the consequences of their illness within the context of forming and sustaining social supports in the community. What remains unclear however is the ways they negotiate, and reconcile, deviant labels with other actors within their social worlds.

The context of contemporary mental health service provision is one of public unease and concern about the dangerous and unpredictable behaviours of mentally ill people (Repper et al, 1997). These concerns indicate that conditionally-discharged people are not returning to welcoming, or even neutral, social settings wherein they can access the necessary supports. To achieve sustained community tenure people subject to conditional discharge may, through their talk, demonstrate identity orientations which will provide new understandings about the work they are doing in managing their community return.

The subjective experience of social actors engaged in community return is one that remains largely unreported. One approach to exploring this experience is through providing opportunities for participants to narrate their experiences. Stories can provide one point of access to the social worlds that

respondents portray in their talk. Forensic mental health populations have to a large extent remained hidden from view. Facilities tend to be isolated or enclosed within large high-walled perimeters. Both general public and media interest are discouraged, and even actively avoided, ostensibly to protect the confidentiality of people receiving care and treatment. There is however more than an air of potential threat to these facilities, and those that reside and work in them, from negative public reaction. The hidden and hard-to-reach nature of these populations may in part stem from a social sensitivity related to identity threats. Research that illuminates how these identities are managed, deployed and negotiated within the context of community return would improve our understanding of these processes. Moreover, research in this field could ensure health and social care providers are better informed about the work that people must do to successfully achieve sustained community tenure. I have taken the position that first-hand accounts of leaving hospital provide a promising approach to developing an understanding of the interaction work that people must achieve.

1.4 THE RESEARCHER

My interest in this area of study was prompted by my professional background as a community mental health nurse working with people with enduring and severe forms of mental distress. Prior to taking up my current academic post I had worked for 14 years with people with serious and enduring mental illnesses in acute inpatient, community and forensic settings. One challenge I encountered in this area of practice was the reticence of workers to involve people in decisions about their care. There was also suspicion of suggestions that people may have valid contributions to make with regard to longer-term arrangements for their care. This is a situation that has gradually changed over the years with significant academic, research and clinical contributions from people who have used services (Rogers et al, 1993; Perkins and Repper, 1996; Beresford, 2000; Campbell, 2001).

While working as a registered nurse in clinical practice I commenced academic studies to gain my first degree in Health Studies and followed this with an MSc in Mental Health Interventions. These programmes allowed significant latitude in assignment topics and I was able to focus submissions on a various aspects of community mental health care. I eventually re-fashioned many of these assignments for submission for publication. These publications ranged on topics from involving people in mental health needs assessment (Coffey, 1995a), and what I saw as coercive mental health policy developments (Coffey, 1995b; 1996) which lacked reciprocity (Coffey, 1997). I continued to develop my interest in exploring the focus of service delivery for people living with enduring mental illness such as those labelled with a diagnosis of schizophrenia (Coffey, 1998a) and the provision of aftercare and support to people in forensic mental health services (Coffey, 1998b) as well as exploring concerns about the use of anti-psychotic medication (Coffey, 1999a).

Both my first degree and my Masters course included research methods modules and I was able to complete projects exploring various aspects of the delivery and organisation of community mental health services. My research has examined outcomes for people living in the community with enduring mental health problems (Jones et al, 1995; Coffey et al, 1996) and the effects of working in forensic settings on community mental health nurses through the use of standardised instruments administered by postal survey (Coffey, 1999b, 2000a, and Coffey and Coleman, 2001). I recognised however that much of my research, while seeking to examine the effects of care delivery, did not access in-depth accounts of participants. I have therefore sought to develop my interest in examining multiple perspectives of workers and those using services. This has included investigating nurses' views on the use of legal restrictions on the liberty of discharged patients (Coffey and Jenkins, 2002; Jenkins and Coffey, 2002), as well as multiple perspectives of specific interventions (Coffey et al, 2004; Coffey and Hewitt, 2008). I have extended my interest to other marginalised groups through analysis of the provision of mental health services within the prison system (Emslie, et al, 2005). My aim

has been to explore aspects of community forensic mental health care including: working with carers of people discharged from forensic hospitals (Coffey 2003), planning care for people with forensic histories (Coffey 2005), community interventions for people diagnosed with personality disorder (Coffey 2006a) and transitions to community living (Coffey et al, 2007).

I registered for a PhD in February 2002 with the intention of addressing multiple perspectives of people on conditional discharge and those working with them to offer support and aftercare. My interest initially was in examining from an ethnomethodological perspective how people negotiated their return to community living following conviction and detention for a serious criminal offence in which mental illness was implicated. I wanted to explore the identity work of people on conditional discharge and how this was supported or challenged by workers. I intended at the very outset to access potential participants through forensic mental health settings that were practically accessible to me. To this end, services that I could practically and repeatedly travel to were identified and approached. Forensic mental health services are not attuned to providing access to researchers originating outside their own organisation. This presented me with a number of problems which I elaborate upon in Chapter 3.

My decision to collect data through face-to-face to interviews was based upon discussions with key gatekeepers and with colleagues in clinical and academic practice. Forensic community mental health services are delivered in multiple and diverse settings, making observation of day-to-day life of service-users impractical. Collecting stories of community return appears to be relatively nonthreatening to gatekeepers. Given the hidden and hard-to-reach nature of the target group, I concluded that in-depth interviews provided a reasonable approach to data collection. The aim was to seek narratives from participants as one way of investigating talk related to negotiating community return with this group. It also became clear to me that, in choosing to use primarily interview data I was making an assumption, based upon the notion that an examination of what people say about events in the form of

stories was sufficient to constitute an analysis of conditional discharge from an actor's perspective. A number of factors moved me on from this position. Firstly my reading on conversational analysis, discourse analysis and my attendance at Master-classes² on discourse and narrative analysis suggested the notion of reading texts with an awareness of its function (Edwards 2006). This, coupled with attendance at a discourse group in my department, led to a developing awareness of the sequencing and structure of stories to achieve the business-at-hand in interaction. It seemed to me that analysis of talk presented the opportunity to explore achievements in talk such as identity (Antaki and Widdicombe, 1998). The application of these ideas in the analysis of talk of people, who have left secure forensic mental hospitals and are attempting community integration, appeared to me to be novel. To my knowledge this has not been explicitly investigated previously.

1.5 THE STUDY

The approach I have adopted in this study has been to seek, through research interviews, first-hand narrative accounts from people who have left forensic inpatient settings on conditional discharge orders. My interest was informed by ethnomethodological interest in the "routine ways in which people make sense of the world in everyday life" (Hammersley and Atkinson, 1995:2). I was also interested in examining how community return was negotiated by participants by examining the action orientation of their talk in research interviews (Edwards, 2006; Wooffitt and Widdicombe, 2006). I have endeavoured to focus upon participants' own orientations. As such I have approached identity as a resource of the participant rather than the analyst (Widdicombe, 1998a). Where I deviate from this I do so in the pursuit of the ethnomethodological endeavour to understand, and bring to bear, wider contextual material. Wetherell (1998) has suggested a synthesis of

² I attended Master-class sessions on discourse analysis presented by Glyn Elwyn and Lesley Griffiths, narrative analysis presented by Catherine Reissman and a class on narratives as resistance by Eliot Mishler. All of these sessions were run by the Qualitative Research Unit and took place at Swansea University between 2002 and 2005.

conversational analytic-informed approaches to interview data and ethnographic attempts at understanding wider social and cultural elements. This seeks to combine analysis of wider social meanings with the situated accomplishment of talk in interaction (Stanley and Billig, 2004).

I recognise the use of wider contextual material within the field of conversational analysis remains an area of contention (Schegloff, 1998; Billig, 1999). I have however made use of wider contextual material to deepen my analysis of the purposes that talk is put to. My instinct has been to treat the use of contextual material conservatively, so that my analysis is, for the most part, informed by participants' own orientations.

The research sample was drawn from two forensic mental health services providing aftercare and monitoring of people discharged from inpatient settings. I commenced data collection in setting one in 2003 following local research ethics committee approval (LREC) and in 2004 following LREC approval for setting two. Data collection continued until June 2006. In all instances service-user participants remained subject to Section 41 of the *Mental Health Act 1983*, which provides for restricted and conditional discharge. I have interviewed twenty people on conditional discharge and the professional workers (nurses and social workers) providing them with aftercare. In total fifty-nine interviews constitute the main data set for this study. All interviews were audio-recorded and transcribed by the researcher. Analysis of the transcripts focused primarily on service-user accounts of community return and the action-oriented nature of their talk. Professional worker accounts were analysed in relation to the ways in which these supported or challenged the accounts of service-user participants.

My intention in completing this research is to make an analytically informed contribution to understandings of care and treatment of people using mental health services. To an extent this has already commenced (see Appendix 2) with publication of emerging thoughts (Coffey et al, 2007) and invited national and international seminars on aspects of policy and practice in community

mental health settings. This study has suggested future areas for investigation related to the use of analysis of talk in understanding the experience of service provision, return to community living and workers contributions to this process.

1.6 SOME ASSUMPTIONS

I recognise that all research is built on certain assumptions or presuppositions. Murphy et al, (1998) have noted that among quality indicators for qualitative research there is a requirement to reflexively address the context of the production of data. This requires an awareness of the researcher's role in contributing to the data collected and the shaping of analysis, and the necessity for a reflexive approach that is clearly explicated. The ways in which qualitative research privileges respondents' versions of the world, to the extent that it deals even-handedly with competing accounts and recognises the situated and context bound elements of the production of accounts, is an important signifier of rigour. With this in mind, I am aware that I hold a number of assumptions about mental health/illness and the place of talk in the social world, which I would like to make clear here at the outset.

First, my orientation towards this study is as a mental health nurse schooled in medical understandings of illness and health. However during my years as a community mental health nurse I became keenly aware of the social nature of mental illness and societal responses to the condition. My academic career has allowed me to pursue these interests in more depth. I hold a number of assumptions based upon this background which Busfield (2001) has usefully summarised and which I draw upon here. These include the notion that social processes help mould how mental health and illness are conceptualised. Social processes set the boundaries and categories that enable these conditions to be distinguished from each other as well as from the absence of the condition. I see mental disorder as the sum of both environmental processes and some yet to be defined, inherent (possibly genetic), vulnerability within individuals (Zubin and Spring, 1977). Professional

workers' responses, in the form of mental health practice, and societal responses, are essentially influenced by social processes and as such these are important foci for sociologically informed exploration and analysis. Although I am not expressly concerned with workers in this thesis, their importance in the experience of illness and its treatment is reflected in the support and challenges they present to service-users' nascent identity work.

A key assumption I have made in this thesis relates to the agency of social actors and how this links with social structures. Agency may be seen as the autonomous and independent intent, purpose and reflexivity of social actors. I see talk in interaction as a means for the enactment of agency in social settings. The term *social structure* differentially refers to categories or groups in relation to one another such as gender, class and ethnicity, as well as enduring patterns of norms (roles) and social institutions embedded in social systems. Dawe (1970:214) has characterised the dichotomy of structure and agency as "two sociologies, at odds with each other and in conflict at every level". He suggests that "one views action as the derivative of system, whilst the other views system as the derivative of action" (Dawe 1970:214). The treatment of structure and agency in the literature varies somewhat. They are frequently held as different kinds of things (Carter and Sealey, 2000), often in perpetual conflict, or as constitutive of each other (Giddens, 1984). One issue appears to be how structure and agency relate and connect to each other. Fairclough (2000:25) has indicated that the links between structure and agency may include the positions (in the form of roles) and practices (in the form of situated activities) of social actors.

My understanding is that within the constraints and freedoms of their world, people make plans and choices for options that help construct their social worlds. This is an interactive process in which social action results from the

"interlocking of intentionalities of social actors rather than from their singular existence"

(Knorr-Cetina, 1981:9).

Social actors demonstrate tacit understandings and creatively engage in the social world, demonstrating cultural values that provide a backcloth to their choice of actions. Social structures may place certain limits on agency³ but it is also the case that actors influence and constitute these very same structures, through interactional involvement with them and with other social actors (Hays, 1994; Carter and Sealey, 2000; Fairclough, 2000; Potter 2000). The degree to which actors can influence and determine social structures may be due in part to the “accessibility, power and durability of the structure in question” (Hays, 1994:62). It is also in part related to the resources available to individuals, the power they hold relative to the structures and the cultural conditions within which they exercise their intent. I see the contextual background in which talk in interaction occurs as being a necessary element in analysis of the business-in-hand in interaction.

Building on the notion of agency and structure as being constitutive of each other leads me to the claim that links can be made between micro-sociological investigation of interaction of individuals, and macro-sociology of the interaction of groups and institutions (Knorr-Cetina and Cicourel, 1981). I am suggesting that analysis of talk in research interviews, which acknowledges the context of its production, can help inform wider discussions of the situated activities of social actors in similar circumstances. This may be a big claim. In this thesis I will attempt to clearly show my analysis of the talk of conditionally-discharged people, and use this analysis for a broader discussion of the lives of others in similar circumstances. I return to this discussion in Chapter 8.

Before moving on to the body of the thesis I wish to say a little about my understanding of the role of accounts. It is perhaps a not uncommon sight in health research to find a nurse doing an interview study in which accounts are assembled from a variety of participants. David Silverman (1998) has suggested that as much as 71% of research papers in the journal *Qualitative Health Research*, over a five year period, reported the use of open-ended

³ Social structures for instance determine the types of freedoms social agents may have access to and in expressing agency social actors may reproduce discourses imposed or required by social structures.

interviews. It has been suggested in mental health nursing that there is some natural alignment between the profession and this approach to data gathering (Cutliffe and Goward, 2000). I sympathise with this view, however it is not the rationale for my approach to this study. Instead I have been informed by an interest in identity work of people leaving forensic hospital and how they account for themselves. Scott and Lyman, have hinted at the potential of an approach that accesses accounts;

“Accounts always occur between persons in roles... a normative structure governs the nature and types of communication between the interactants, including whether and in what manner accounts may be required and given, honoured or discredited”.

Scott and Lyman (1968: 58)

I have set out to explore the discharge of people, from forensic mental health hospitals, to communities which may fear them, isolate them and otherwise discriminate against them. In doing so, I have been challenged to address issues of identity as being fundamental to this process. Strauss has suggested however that identity is not only intangible but also an outcome of interaction;

“Identity as a concept is fully as elusive as is everyone’s sense of his own personal identity. But whatever else it may be identity is connected with the fateful appraisals made of oneself- by oneself and by others”.

Strauss (1959/1997:11)

Based upon this notion of identity negotiated in interaction, my assumption is that identity is achieved in the utterances of social actors. Scott and Lyman put this somewhat similarly;

“Every account is a manifestation of the underlying negotiation of identities”

(Scott and Lyman, 1968: 59)

1.7 ORGANISATION OF THE THESIS

In this opening chapter I have outlined my research objectives, my rationale and my approach to studying this aspect of social life. In Chapter 2, I provide a discussion of the policy and practice foci related to the provision of community mental health services, and more latterly the involvement of forensic services in this venture. I outline some of the significant social hurdles facing people with mental health problems. These include public and professional responses to the condition and the discrimination and prejudice that follow. Community return appears to depend for its success upon opportunities to engage and integrate with available social networks and people leaving forensic services struggle to gain this access. I discuss the concept of identity and its negotiated nature in social settings. I suggest that sustained community tenure may in part depend upon the successful deployment of new, or emergent, identities accomplished in the talk of people leaving hospital. Community return may lead to significant threats to the identity work of people. I argue that the literature on social sensitivity provides a useful access point to exploring these threats. I conclude my overview of community mental health literature with reference to research which has explicitly sought to explore service-users' views in forensic settings. This research is relatively sparse and I note significant problems in the conduct and reporting of studies.

In Chapter 3 I provide a discussion of my methodological approach to the investigation of talk of people on conditional discharge and the workers providing them with aftercare. I outline my approach to exploring narratives based upon an intention to investigate the work achieved in stories told in research interviews. I provide a rationale for my use of research interviews as a means of data collection and outline some limitations associated with this approach. A description of both research settings is provided to establish the context of service provision in each area. In this chapter I present an account of my attempts at gaining access to the research settings. I argue that negotiating access is not a one-off event and I show how it was necessary to

renegotiate access periodically throughout the three year period of data collection.

The requirements of research governance have placed a significant onus upon researchers to ensure that projects meet a range of ethical and structural standards. In Chapter 3, I describe the steps I have taken to gain ethical approval and address the implications of securing informed written consent in populations where questions of capacity to consent may be a feature. I provide a description of how the data for this research were handled in relation to recording, transcription and analysis of talk. I conclude this chapter with a return to the issue of social sensitivity in researching hard-to-reach and partially hidden populations. I suggest that social sensitivity may be one reason for reluctance on the part of street level workers and service-user participants to participate in research. Finally in this chapter, I conclude that social sensitivity is an issue for researchers to address in securing and sustaining access, as well as an issue within the research interviews themselves.

I begin my analysis of the research interview data in Chapter 4 by examining talk about entry to the forensic mental health system. Although participants were asked to tell their stories about discharge from hospital, many chose to tell of their admission to the forensic system. I explore what was being accomplished in these stories about criminal offending and admission to a forensic hospital. I will show how this talk achieved claims of illness as causative explanations for deviant behaviour. I will show how identity work to establish the person as a moral agent suffering from disrupted biographies was placed alongside claims of illness.

In Chapter 5 I move on to examine participants' talk about conditional discharge. In this analysis I focus on aspects of time and rhetoric which were used in the talk of participants to orient towards identities as credible narrators of established facts. Service-users' stories of discharge are seen to be rhetorically organised to establish the accounts as authentic, credible and

aware of competing versions. I show how competing accounts were evident in the talk of workers providing aftercare services to the person. A feature of the talk of service-users was the telling of stories which demonstrated time-oriented positive directionality. This was the orientation towards improvement in their condition and greater liberty as time passed. This emphasis on time and directionality worked to construct the recovering, rational person with clear grounds to talk about conditional discharge.

My analysis in Chapter 6 examines service-users' talk in relation to aftercare monitoring. I explore how participants talk about living in the community on conditional discharge and how aftercare arrangements are constructed in accounts. I show that the talk of participants was concerned with the degree of control over their lives which was sanctioned by the use of Section 41 arrangements. These arrangements are both formal and informal and participants' talk functions as complaints about the implications of these powers. For some participants, the identity-relevant aspects of intensive aftercare and follow-up from health, social care and criminal justice agencies were constructed as significant downsides to aftercare support. Professional workers' talk is examined to show how readiness to wield the power of recall is cast as benevolent risk management. I also show how workers engage in subtle undermining and categorisation of service-users' accounts, in what might be regarded as challenges to identity and a struggle for ascendancy of which account predominates.

Chapter 7 presents my analysis of what I discern as emergent identity work in the talk of service-user participants. I first address the issue of social sensitivity and the handling of this in the talk of people on conditional discharge. My analysis shows how sensitivity in social situations was retold in the stories of people on conditional discharge. Moreover research interviews as a site of social interaction are also sites for the handling of socially sensitive information. In research interviews participants accomplish the management of threats in their talk in ways which may be informative of their attempts in other settings. One way of handling identity threats was through

the construction of new or emergent versions of social identities. These were sequenced in talk to follow distancing, in time and place, from older identities. I show how stories functioned to achieve claims of ordinariness as an emergent identity form. Positive directionality is firmed-up by use of emergent identity work. This demonstrates progress and an attempt at movement away from previous identity labels. Stories told worked as a type of resistance to imposed labels of deviance.

In Chapter 8 I draw together the various strands of my analysis to examine identity work on community return for people leaving the forensic mental health system. I suggest that much of the identity work of participants is concerned with achieving successful transition towards new social identities. Talk is the means for achieving this social action. Building upon this I return to the notion of transition, as featured in the rites of passage work of Arnold vanGennep (1960) and Victor Turner (1969), and present an analysis of incarceration and discharge as a form of identity transition. I argue that this transition is ongoing and that for many people discharged from forensic mental health settings there is an enduring liminality to their identity work. Turner's (1969) notion of 'threshold people' is employed to support my claim of emergent identities in talk of people on conditional discharge.

I conclude the thesis in Chapter 9 with a summary of the main findings and indicate what I see as the main contributions of this research to the development of theory, research and clinical practice. I suggest a number of areas for further investigation based upon my findings.

CHAPTER 2: RETURN TO COMMUNITY LIVING

2.1 INTRODUCTION

This chapter presents an analysis of the literature on the health and social care of people with long-term mental health problems living outside of hospitals in communities. One particular subset of this group referred in the literature as mentally disordered offenders is now increasingly cared for outside of hospital (Webb and Harris, 1999; Buchanan 2002) and it is with this group in mind that I address policy developments and the social environment for the provision of community mental health care in England and Wales.

Those who commit serious offences in the context of mental illness and who are then detained for treatment and eventually discharged to community living, may encounter particular personal and social hurdles in attempts to re-integrate. Arrangements for aftercare monitoring of discharged people on Section 41 of the *Mental Health Act 1983* to a large extent determine the boundaries for re-integration attempts. I address here issues of stigma/discrimination, social capital, community adjustment, and transcarcerative social control in an attempt to provide an analysis of the political and social context for the provision of community mental health care to people leaving forensic mental health facilities.

The main focus of the literature and research in this field has perhaps understandably been upon recidivistic behaviours of discharged people. Such a focus however neglects how people re-establish themselves in communities as viable citizens. My analytic interest is in examining talk as social action and in particular how service-user research participants' articulate identities in talk. In this chapter I present a theoretical overview for this focus and examine both the formal and informal context of community return on conditional discharge. I analyse the literature on social processes

with particular emphasis on deviant labelling and the effects upon the individual. I examine possible ways of addressing these effects in the form of social bonding, social capital and a more recent interest in the concept of recovery in mental health services.

I argue, based on a review of published research in this field that studies of the accounts of people who use mental health services remain limited in range, depth and quality and suggest that this leads to a lack of credibility of research findings. One consequence of this is the perspectives of some of the key groups of social actors have not been incorporated in the developing knowledge of this field.

2.2 CONTEXT OF COMMUNITY MENTAL HEALTH CARE

In the UK community mental health care, as elsewhere in the industrialised world, emerged in the years following the end of the Second World War. The occupancy of inpatient beds fell from its peak of 350 per 100,000 population in 1954 to 151 per 100,000 population in 1982 (Boardman, 2005). The closure of old mental hospitals and the move towards community provision has gathered pace in the last 20 years (Bell and Lindley, 2005). Goodwin (1997) has summarised the variety of factors driving forward community care which included the development of new medications; the materialisation of more enlightened professional attitudes; imperatives to reduce the cost of expensive hospital services; increased lobbying from organised groups of carers and service-users; the influence of anti-institutional critiques, and the emergence of anti-psychiatry ideas. These factors have combined to raise questions about bio-medically-dominated, hospital-centred mental health services (Goodwin, 1997). Taken together these developments have led to a greater emphasis on the provision of care and treatment outside of the large institutions that had themselves become synonymous with enquiries into failures in care (Martin, 1984). For many service-users and professionals community care is significantly preferable to institutional care (Leff et al,

1994), and has helped deliver an improved quality of life (Anderson et al, 1993) although cautions about uncritical adoption of the policy have been voiced (Pattison and Armitage, 1986).

The system of community mental health care has been criticised for its lack of professional and organisational role clarity (Hannigan, 1999a). For instance Galvin and McCarthy (1994) noted that multi-disciplinary community mental health teams lacked focus, were inefficient and tended to deliver poor quality services. Policy frameworks, too, have sometimes been inconsistent and contradictory. For example, guidance on the coordination of health care and social care was contradictory throughout the 1990s (Hannigan, 1999a). Despite the shift in emphasis towards community care it has been noted that it is comparatively under-resourced. The Audit Commission found that two-thirds of all resources for mental health care were tied up in hospital services (Audit Commission, 1994). Most damningly, central government controversially declared that community care had 'failed' (Department of Health, 1998), a claim strongly repudiated by professionals who noted that resources had not followed patients into the community and as such the policy itself had not been fully implemented (Thornicroft and Goldberg, 1998).

Concerns about the policy of community mental health care have been likened to a form of moral panic related to fears of dangerous people returning to live in the community (Holloway, 1996; Ungar, 2001). The stability of the notion of moral panic however has itself been questioned. These notions are likened to roulette dynamics in which perceptions of folk devils are constantly shifting (Ungar, 2001). Public anxieties are thus seen as somewhat free-floating and likely to alight upon whatever issue is considered newsworthy in attracting media attention. Nonetheless public anxieties about mental illness are frequently reawakened and appear to endure. These anxieties are arguably reflected in political declarations and initiatives which appear in part to be aimed at demonstrating government competence in tackling perceived shortcomings in service delivery (Boardman, 2005).

The political response to the supposed failures of community care has been to produce central guidance, policy and legislative changes to allow greater control and monitoring of people discharged from mental hospitals (Wells, 1998). These responses however have often attempted to juggle notions of involvement and participation with those of control and coercion. This has raised concerns among workers both in terms of their relationships with service-users and central control of clinical practice (Godin and Scanlon, 1997; Grounds, 2001). Godin (2003) has noted that workers such as nurses are now merely operatives of the system wherein control and hence power has passed from clinicians to those in administrative positions. Wells (1997) has argued that street level workers attempt to balance the requirements of the system (in the form of policy) versus the needs of their professional and peer cultures. The outcome of this process is that coercive policy directives are in effect mediated by street level workers.

Mental health policy has emphasised evidence-based practice and participation of service-users in services (National Assembly for Wales, 2001; WAG, 2005). However legislation, as proposed in the *Draft Mental Health Bill*, sought to create new groups of patients (for instance people with severe and dangerous personality disorder) for whom there is currently a lack of an evidence base for treatment (Manning 2002), has de-emphasised involvement and participation of service-users and planned to extend coercive compulsory treatment beyond the walls of the hospital (Joint Committee on the Draft Mental Health Bill, 2005). These proposals have now been realised in new legislation (Department of Health, 2007). Legislative and policy developments appear to be contradictory and may lead to tensions in the delivery of community mental health care as both service-users and clinicians attempt to negotiate collaborative helping relationships within the context of compulsory care.

2.3 FORENSIC MENTAL HEALTH CARE

The developments in broader mental health policy have been reflected in changes to forensic mental health services although perhaps at a slower pace. Forensic mental health services provide health and social care to people with enduring mental health problems who have usually been convicted of serious criminal offences against the person. Historically people with a criminal conviction and mental illness have been detained under the *Mental Health Act 1983* and treated in large monolithic prison-like institutions, often for many years. People leaving these forensic services on conditional discharge are subject to levels of compulsion, supervision and monitoring which are unique within the UK health and social care system. For instance they may be required to reside in specified accommodation, attend particular activities, comply with medication and other treatments and allow access to their home by health and social care professionals for the purposes of supervision and monitoring.

Forensic mental health care in the UK has a long history dating back to the *Act for the Safe Custody of Insane Persons Charged with Offences 1800* which followed the attempted shooting of George III by James Hadfield, an ex-soldier, earlier in that year (Moran, 1985). The Court accepted that James Hadfield had comprehensive delusional ideas which had been caused by brain damage following a serious head injury. The retroactive legislation provided for the special verdict of "*not guilty by reason of insanity*" for those who were insane at the time of the offence, although it contained no definition of insanity. A return of this special verdict meant that the accused person would be detained in "*strict custody*" in the County Gaol at His Majesty's Pleasure. It was however recognised that prison was unsuitable for the care and treatment of ill people and in the early 1800s, the Governors of Bethlem Hospital agreed to include a 'Criminal Lunatic Asylum' as part of a new hospital development (Forshaw and Rollin, 1990).

Since the 1800s there have been a series of developments in terms of service provision and health policy. For instance, new high security hospitals were built and subsequent legislative changes in mental health law have provided the courts with the means to detain for the purposes of treatment those who have committed serious offences in the context of mental illness. Policy development has most recently culminated in the *Reed Report* (Department of Health and Home Office, 1992) which reaffirmed the policy that mentally disordered offenders (a term most often applied to people using forensic services in the health and social care literature) should as much as possible be cared for by health and social services rather than the criminal justice system. The main principles of forensic health and social care suggested by the *Reed Report* were that people should be cared for;

1. With regard to the quality of care and proper attention to the needs of individuals
2. As far as possible in the community rather than in institutional settings
3. Under conditions of no greater security than is justified by the degree of danger they present to self or others
4. In such a way as to maximise rehabilitation and their chances of sustaining an independent life
5. As near as possible to their own homes or families if they have them

These principles have been a significant driving force in service development ranging from reviews of high security provision to the development of local secure services and community mental health aftercare services.

There are currently three high security mental health facilities for England and Wales, known as the Special Hospitals. High security facilities are provided for people who demonstrate significant dangerous behaviours and who require a level of security that is otherwise unavailable within mental health services. The Special Hospitals are large, regionally-distant institutions which are reminiscent of Victorian mental institutions combined with prison-like levels of security. Special Hospitals have been supported by a large scale building programme of regional medium secure services which followed the

Reed Report recommendations. Medium secure units were envisaged as 'step-down' provision for patients moving from higher levels of secure care to lower levels of security with the aim of providing rehabilitation and preparation for eventual community return within two years of admission. There are now also a number of low secure services beginning to emerge at local level which on some occasions are used as a further stepping point towards eventual discharge. All of these facilities are provided by the National Health Service. A number of privately run medium secure services have also been established partly to take advantage of the shortfall in provision within NHS facilities and many of these now have contractual agreements to provide longer term (that is greater than 2 years) placements.

2.4 RISK

One of the prime requirements of forensic mental health services has been the safe management of risk behaviours. The development of 'risk thinking' has been pervasive in all mental health services to the extent that decisions on care and treatment are influenced by considerations of risk, despite the term itself being poorly defined and understood (Pfohl, 1978; Rose, 1998). While services may seek to operate in ways that provide transition towards eventual discharge and greater liberty it is also the case that movement may occur in the opposite direction too. Heyman et al, (2004) have applied the concept of a risk escalator to forensic services. 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.

Within the new arena of community care forensic mental health services are challenged to manage risk behaviours of people who are seen as unpredictable and historically dangerous by virtue of their previous actions. Most research in this area has been concerned with attempts at actuarial predictions of future offending or risk behaviours. An exemplar of this approach is the MacArthur risk assessment study of mental disorder and violence and with a sample of over one thousand people it remains the largest study in this field (Monohan et al, 2001; 2005). Actuarial studies of risk such as the MacArthur risk assessment study have been attempting to delineate a range of factors that are considered to be predictive of risk status.

The concern to predict and manage possible future behaviours has become a central and core task of many mental health services and particularly community mental health nurses (Godin 2004). This concern with risk is not however peculiar to mental health services but reflects a wider societal risk-averse culture in which perceptions of high profile but low probability risks are associated with public anxiety for state intervention and action, in contrast with low profile high probability risks which are seemingly accepted without concern (Lupton, 1999). Calls for greater control and compulsion of people with mental illness to accept treatment and care because of the possible fatal dangerous behaviours they may exhibit bear little relationship to the actual risk presented, which is much lower for instance than deaths in road traffic accidents (Taylor and Gunn, 1999).

There have been significant consequences arising from this focus on risk for both those receiving services and those delivering them. One outcome can be read as a concern to extend the power of the professions and by proxy the state beyond the walls of institutions. Amendments to the Mental Health Act contained in the *Mental Health Act 2007* provide extended powers for supervised community treatment of people discharged from generic mental health services. In forensic mental health services these extended powers exist in the provisions available in the *Mental Health Act 1983*. These provisions allow for conditions to be placed on a convicted person detained under Section 37, to restrict and place limits upon discharge under Section 41. This is commonly known by workers and service-users alike as conditional discharge.

2.5 CONDITIONAL DISCHARGE: AN OVERVIEW

Community return of people leaving forensic services received renewed focus in the wake of the *Reed Report* which advocated the development of collaborative community health and social care forensic services (DoH/Home Office 1992). This presents significant challenges to those providing as well as for people receiving these services. These challenges include working with and managing potential dangerous behaviours in the relatively uncontrolled environment of wider society and within the context of greater involvement and collaboration with recipients of services. From a service perspective the Mental Health Act provides the means to exert control and a degree of compulsion upon those discharged from inpatient facilities. The calls for service-user involvement and partnership however while having a certain moral resonance have not (so far) had the same authoritative weight of legislation behind them (Beresford, 2001).

The principal legislation governing detention and treatment of people with mental illness in England and Wales is the *Mental Health Act 1983*. The Crown Courts have at their disposal a range of provision within the Mental

Health Act which they may use when convicting people of serious criminal offences against the person in the context of a diagnosable and treatable mental illness. Section 37 of the Mental Health Act allows the Crown Court to detain a person, on conviction of a serious offence, in hospital for treatment and this section is often used in conjunction with Section 41 which prevents and restricts discharge unless granted by the Home Office or a Mental Health Review Tribunal⁴. In the majority of instances where discharge is granted it is on a conditional basis subject to supervision and monitoring arrangements which may include attendance for treatment, permitting the care team access to living arrangements, attendance at organised day time activities and restrictions on travel or contacting particular individuals. In all cases the Home Office retains the right to recall individuals to hospital and it may do so on the advice of the supervising care team, or more unusually independently of this advice.

There are approximately 1,200 detained patients in the three Special Hospitals in England (DoH 2002) out of a total detained mentally disordered offender population of just over 3,000 (Johnson and Taylor, 2002). There are also approximately 1,300 court and prison decisions each year using Part 3 of the Mental Health Act 1983 (DoH 2002). This includes approximately 300 people detained on Section 37 with restriction orders (Section 41). Many people receiving these decisions will be transferred to medium secure services and it is estimated that 88% of these are male, predominantly single with half being between the ages of 21-30 years old (Street 1998). Violence against the person makes up the majority of offences with which mentally disordered offenders are charged or convicted. 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 (Home Office 2007).

⁴ Previous Mental Health Acts such as the 1959 Act included similar provision for the restricted discharge and monitored aftercare of people convicted of a serious offence and detained for treatment of a mental disorder.

In the year 2005, the most recently available figures, 257 people were discharged from hospital on conditional discharge (Home Office 2007). It has previously been estimated that 25 per cent of people conditionally-discharged are likely to be recalled to hospital at some point due to concerns about their risk or their mental health (Street, 1998) and most recent figures indicate that approximately 3% of those discharged between 1999 and 2003 committed serious offences following discharge (Home Office 2007).

Conditional discharge as a method of community follow-up and aftercare is seen by many as a highly successful approach to safely returning people to live outside of secure facilities. This conclusion is most usually based on an actuarial assessment of the risk to the general public from those discharged. For example, Gibbens and Robertson (1983) conducted a 15-year follow-up study of male offenders receiving hospital orders in the years 1963-64 to determine re-offending, convictions, hospital admissions and death. There were 249 men alive 15 years later and of these 42% had had no court appearances, 28% had one or two court appearances and 30% had had 3 or more. Of those who re-offended 2 men had committed homicide, 1 had committed arson, 6 wounding with intent or grievous bodily harm (GBH), 24 aggravated bodily harm (ABH). Half of all convictions were within 12 months of leaving hospital. Gibbens and Robertson (1983:368) conclude that the;

"results do not suggest that hospital orders failed to protect the public from dangerous offenders".

More recently reports by Kershaw et al (1997), Street (1998) and Johnson and Taylor (2002) have presented data on the numbers of recalls to hospital, the number of admissions under Part 3 of the Act and the number of conditional discharges. The general consensus of these reports is that conditional discharge works, it protects the public and it ensures that problem behaviours are detected and addressed promptly. From this view point the return to community living appears to be one which is uncomplicated and effectively managed by agencies charged with the support and treatment of recently discharged people. This focus on counting numbers of incidents and

on recidivism tends to obscure some real concerns about how people leaving forensic facilities are challenged in re-establishing themselves as viable community citizens. In the next section I will review some of these concerns with particular reference to the literature on societal responses to people with mental illnesses in the form of deviance, labelling and stigma.

2.6 DEVIANCE, LABELLING AND STIGMA

It has been suggested that the cost of community care in the UK has been profound public indifference to the plight of the mentally ill (Morrall, 1999). Large scale surveys in the UK have revealed that; the general public were embarrassed and frightened of the mentally ill, the mentally ill were seen as unpredictable and prone to violence, and that mental illness was equated with other stigmatised identities such as paedophilia (Huxley 1993, Read and Baker 1996, Repper et al, 1997). Such attitudes appear to be entrenched and resistant to change. It is within this context of fear and ignorance that people with mental health problems leaving secure forensic services must attempt community return and integration. The potential for discrimination and social exclusion that appears to accompany public anxieties associated with mental illness and criminal offending is significant. In such a context people leaving hospital are challenged to achieve successful reintegration into their communities where they may be viewed as an outsider.

There is a long tradition in sociology of exploring the social lives of 'outsider' groups (Becker, 1963). One outcome of this interest has been the theoretical development surrounding the concept of deviance. This has immediate relevance to an understanding of the context of community return. For instance, one long standing concern with regard to mental ill-health is that rather than the indifference that Morrall (1999) suggests, social actors may actively achieve negative labelling and subsequent stigma. Goffman (1963:9) noted that the consequence for the person was to be "disqualified from full social acceptance". Mental illnesses are a source of continuing concern to

the general public as I have noted. This apparent deviation from the norm is tagged as such and seen as deviance. Some authors have suggested that deviant labelling is primarily a result of the behaviours of the mentally ill (Clausen 1981) although this view is limited by its rejection of wider social processes that may be involved in the development and maintenance of mental distress.

Incidents of residual rule breaking which are successfully labelled are seen as deviance and thus invoke societal response (Scheff 1966/1984). There is however a selective response to rule breaking in that not all rule breaking leads to a deviant label. When rules are enforced within society the consequence is that rule breakers are liable to be labelled deviant (Becker 1963). This is one way in which the wider social group protects itself against what may be regarded as social problems. Social problems, argues Lemert (1972) are part of a climate of opinion within communities which anticipate social control needs.

Erikson (1962) has noted that naive acts of deviance are provoked by strains in the social situation of individuals but once this is set in motion deviance develops its own forms of organisation and can persist and remain intact over time. Becker (1963) has argued that deviants are those who are successfully labelled although he recognises that this category does not include all those who might be labelled. In other words not everyone who engages in deviant behaviour will be labelled and as such the usefulness of the term for describing groups may be limited. 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). Coupled with this is the observation that such processes are, at their heart, transactions between social groups and individual social actors. As such they require examination of both the moral entrepreneurs who impose morality and the person deemed deviant (Becker, 1963). Erikson (1962) has further observed that society requires and as result creates the conditions for

deviance as a type of boundary maintenance⁵. This view appears to be built on Durkheim's (1895/1982) observation that crime, or perhaps deviance more generally, is a natural kind of social activity.

Erikson's (1962) observation that the audiences who view deviance are fundamentally important in the activity of labelling any behaviour as deviant, was an important contribution to understanding not only deviance but also the consequences of being so labelled. We can understand deviance then as conduct that requires the attention of social control agencies prompted by concerns of the societal body to protect itself. It is also to be understood as not inherent in individuals or groups but rather conferred upon forms of behaviour by wider social groups (Erikson 1962). The focus on deviance then is a focus on how society organises to determine (label) deviance and the sanctions it applies to behaviours deemed deviant.

Becker (1963:176) cautions against seeing deviance as something special or depraved, rather it should be recognised as behaviour which some value and some disapprove of. As such he argues that closer contact with people being labelled may provide the means to guard against adopting either extreme position.

The notion of labelling theory appears to have emerged out of studies of the sociology of deviance (Lemert 1972) although Howard Becker himself later⁶ argued that this was less a theory with all the trappings this suggests⁷ and more a focus for examining the activities of others such as those doing the labelling⁸. Scheff's (1966/1984) original contention that labelling of residual

⁵ Erikson (1962) has argued that deviance is a necessary part of society as it enables determinations about where the boundaries lie between non-deviant and deviant behaviour and where and how social mechanisms can be used and extended to.

⁶ Becker's paper entitled "Labelling theory reconsidered" delivered to the British Sociological Society in 1971 was appended as an extra chapter to editions of "Outsiders: studies in the sociology of deviance" from 1973 onwards.

⁷ For instance being able to determine why people do things that are deviant while others do not and being able to determine who was liable to be labelled as deviant.

⁸ Becker's preference was to use the term "interactionist theory of deviance" to emphasise what he saw as the collective action of social groups to determine and therefore label deviant behaviours.

rule breaking in mental ill-health leads to persistent negative effects for the individual, and also influenced others' behaviours towards that individual, proved controversial (Gove, 1970). Nevertheless a focus on labelling has persisted in the literature and prompted further studies (Rosenhan, 1973).

A particular concern has been the endurance of the effects of the label which Link (1987) and Link et al (1987) have shown to include social rejection, maintenance of social distance and discriminatory responses of social groups such as professionals charged with caring for the mentally ill as well as the wider social body. In particular people with mental illnesses have been shown to have incorporated wider negative social attitudes into an expectation that they will experience similar discrimination once they have suffered an episode of illness (Link 1987). These assumptions include that others will find them less intelligent, less trustworthy and less likely to have important things to say leading to demoralisation, income loss and unemployment in labelled groups (Link 1987:98).

Mental illness labels in effect allude to and can be interpreted as a collective understanding of the kind of person someone 'really' is. These labels provide at once a description of the person's position in society and a profile of the type of character we are to understand them to be. The commission of serious crimes leads to a view of the person as a "true outsider" (Becker 1963:3) and coupled with mental illness suggest significant implications for the individual. This can create a range of social hurdles which the person must overcome in attempting to re-establish and reintegrate themselves into the wider social group.

Lemert (1972) notes that unanimity and consensus suggested by successful labelling is inconsistent with the handling of deviance in society. For instance, he notes that social groups alternately offer help and rejection, suggesting a duality of approach in societal reactions which the person who has been labelled has to contend with in their interactions with other (sometimes more powerful) social actors. This suggests that attempts to enjoy full membership

rights in social systems for people labelled deviant will be something of a struggle.

One response to the struggle to involve people with mental illness in full participation within communities has emanated from a disability access perspective based upon a concern about violation of human rights (Farmer 1999). Some authors have suggested that mentally ill people as citizens should enjoy the same rights and access as the rest of the population. For instance Sayce (1998) has argued that we should move our discussion of stigma toward a discussion of discrimination. She sees the focus on stigma as distracting from the problem of discrimination and advocates a shift toward directing interventions at those who perpetuate the discrimination (Sayce, 1998). This is more than a semantic shift of replacing the word stigma with the word discrimination; it instead suggests a need for significant social and cultural changes in the ways in which people with mental illness are seen and responded to by the general public. Indeed Thornicroft (2006) has argued that a central emphasis on changing societal behaviours, in the form of discrimination, may be more fruitful than attempts to alter attitudes, in the form of stigma.

The size of the task confronted by people leaving hospital becomes clearer when examining the social contacts of those with enduring and serious mental ill-health. People with serious mental health problems are often isolated within communities and studies in the UK indicate the social networks of the mentally ill decrease steadily over the course of their condition and typically amount to just 7 people consisting for the most part of professionals and other service-users (Creswell et al, 1992). Only a minority of people with serious mental illness in economically developed countries actually achieve full time paid employment and the consequence of this is further social and economic exclusion, limiting opportunities for developing and sustaining relationships and developing and maintaining social skills (Marwaha and Johnson, 2004).

The concern about stigma and discrimination that can be experienced by people living in the community with mental ill-health may however be more than the sum of its parts and relate to wider inequalities within social settings. Forces within society itself such as 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 combined negative effect of social, economic and political factors upon the health and social well-being of social actors (Farmer 1996). This combination of factors shapes both the social context for the development of ill-health and how it is responded to by health and social care providers.

Kelly (2005: 722) has demonstrated the relevance of the concept of structural violence to serious mental illnesses such as schizophrenia and argues that problems associated with the condition such as social exclusion, homelessness and violation of human rights have more to do with the ways in which the illness is "patterned, interpreted and treated by societies" rather than a consequence of the illness itself. For instance, one outcome of responses to people with mental health problems is that they are disproportionately represented in numbers of people arrested and imprisoned compared to non-mentally ill people (Teplin, 1984; Office for National Statistics, 1998). Teplin (1984) noted that for similar offences, people with mental illness had significantly greater chances of being arrested than those with no mental illness. People returning to live in the community from forensic services are therefore challenged not solely by their own ability to access and sustain social networks but also by the ways in which society itself responds to mental illness.

Determinations of deviance or "the manner in which a community sifts these telling details of a person's overall performance" are essentially the application of social control mechanisms (Erikson, 1966:7). Once a behaviour is determined to be deviant it is liable to be labelled as such. These labels appear in themselves to carry much weight, to endure and in some cases such as with mental illness labels, they are particularly sticky. One outcome

of deviance labels is that they serve to highlight those for whom social control measures are available.

2.7 TRANSCARCERATION

The concern that people with mental illness are disproportionately represented in the criminal justice system has also been noted by some to be a response by the societal body to control those who may be deemed 'deviant' (Aubert and Messinger, 1958; Lowman et al, 1987b). In this respect the criminal justice and mental health systems cannot be seen to be separate systems operating independently but rather parts of established mechanisms within society that operate to manage deviance (Conrad, 1992).

In tandem with the move towards community care which forensic services have latterly participated in, there has been a large-scale hospital closing programme in the UK (Boardman, 2005). This would seem to suggest that more care was now being received in the community by people with mental illness. It has been argued however that a quieter, stealthier re-institutionalisation is progressing across many western European countries (Priebe and Turner 2003). Evidence of this re-institutionalisation may be found on closer inspection of the total number of in-patient beds in forensic mental health facilities. In recent years the numbers of forensic medium and low secure beds has been increasing steadily – in some areas the numbers of such beds have increased by as much as 100% or more. The proportion of people with mental health problems in prison and in other supervised settings has also been noted to have increased (ONS, 1998).

Forensic mental hospitals provide one part of the means for effective social control of mentally disordered offenders. However social control mechanisms also extend far beyond the walls of forensic mental hospitals. Leaving forensic mental hospital care to return to community living is in many cases a highly scrutinised and supervised process in which the person effectively

remains available for monitoring within the wider medico-judicial system. The movement of people between mental institutions, prison and in some cases community supervision and welfare control is seen as a perpetual cycle of channelling people towards institutional regimes and has been conceptualised by some as a form of transcarcerative social control (Lowman, et al, 1987a; Arrigo, 1997).

Moon (2000) has suggested that the failures in supervision of the mentally ill living in the community have now given rise to a renewed discourse of confinement within mental health policy targeted at people seen to be the most unpredictable and dangerous. The move from hospital to the community rather than being seen as a one step process towards independent living is instead now being managed and broken down into ever smaller steps. This may be one result of concerns related to risk management which in effect elongate the risk escalator towards eventual absolute discharge (Heyman, 2004). Arrigo (2001:162) refers to people in such situations as “prisoners of confinement”. Rather than perhaps the more utopian and libertarian ideal of collaborative and independent living that community mental health care might aspire to, the reality is that many people with mental illness have swapped one type of institution, the mental hospital, for more subtle forms of supervision and scrutiny within the wider community (Cohen, 1985; Steadman and Morrissey, 1987; Armstrong, 1995).

2.8 SOCIAL SUPPORT AND SOCIAL BONDING

Achieving successful community return and reintegration appears to be based upon a number of overlapping elements such as social support, the effect of this upon integration with the wider social body and the possibilities suggested by recovery from mental health problems. For many people, leaving forensic services is a step into the unknown. In many cases the original offence will have received public attention and notoriety. They may have committed serious offences against members of their own families or communities

making the task of accessing non-professional support and regaining previous roles more difficult.

Perkins and Repper (1996) have likened the social support needs of the seriously mentally ill to the needs of the physically disabled in that both groups require assistance to negotiate the able-bodied world. This essentially advocates a social disability and access model (Lester and Tritter, 2005). That is, mental illness, or more accurately the consequences of mental illness create social disabilities and as a result the person experiences social exclusion and requires help to facilitate access to the social world. These social disabilities may be multiplied for people with mental health problems who have committed serious offences making access to social support and establishing new roles a greater challenge.

The concept of social support is one which is often considered to be an important part of maintaining community tenure but less often adequately described. One example of efforts to describe social support is provided by Thoits (1982:147) who defined it as;

“the degree to which a persons’ basic social needs are gratified through interaction with others”.

Basic social needs for Thoits included affection, esteem or approval, belonging, identity and security. These may be met by either the provision of socio-emotional aid (affection, sympathy and understanding, acceptance and esteem from significant other) or the provision of instrumental aid (advice, information, help with family or work responsibilities, financial aid). Tanzman (1993) considered the need for ‘material’ supports among the mentally ill and suggested that service-users themselves are aware that their ability to manage at an optimum level of independence in the community is dependent upon other supports and services. Support for the mentally ill it seems should be an inclusive term that incorporates assistance with money management, advice about day-time activities, emotional support as well as working with people to achieve their treatment goals. Informal care-givers will often meet

many of these support needs and Macinnes (2000) has suggested that problems of burden, coping and personal support of carers by friends and the wider community are important foci for workers.

Social support may help people leaving forensic inpatient services to successfully return and sustain living in the community however Suls (1982) has indicated that social support may also have negative consequences such as creating uncertainty and worry, reinforcing negative labelling or discouraging treatment compliance. This is not to suggest that social support should be treated with caution but rather that it is rarely value neutral.

Despite the potentially negative elements of social support there are other benefits to be gained in improving social supports among mentally disordered offenders. There is some data suggesting for instance that social supports may help in reducing violent behaviour among those mentally ill persons who can be a danger to others (Estroff et al 1994). Simply providing an improved social network however may not be sufficient. Lazarus and Folkman (1984) have suggested that the ability to draw on social support is itself a coping skill and as such poor social skills or illness related symptoms may reduce this ability.

The notion of social support may be insufficient in itself to capture the complexity of the task presented by returning to community living after many years in secure mental health care. More subtle fine-grained theoretical concepts can be applied to develop understanding of these processes. Grusky et al (1985:50) for instance 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”.

As such Grusky et al applied these concepts to a large US sample (n=971) of adults which they term chronic and severely mentally ill. They use the term social bonding as an alternative to the terms social network and social support and conceptualise it as “moderating or buffering stress” (1985:52). Social bonding therefore is seen to positively influence adjustment. Based on

analysis of their data, Grusky et al propose a model of adjustment and service use among those with enduring mental health problems. This is comprised of three types of social bonding, two types of adjustment and two types of service use (see figure 2:1)

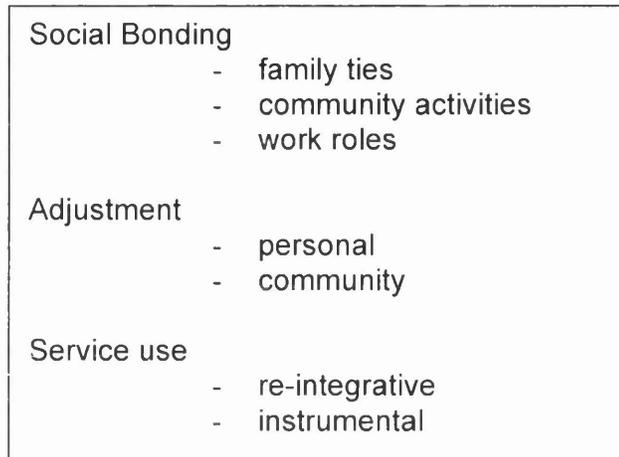


Figure 2:1. Components of Grusky et al's (1985) model of adjustment & service use

The constituent components of this model were used as measures of adjustment in a sample of 917 people with enduring mental health problems (Grusky et al, 1985). Social bonding was measured by presence of contacts with family or spouse, the strength of relationships outside the home and the number of hours employed per week. Personal adjustment was measured by self-care activities and community adjustment was measured by frequency of deviant or disruptive behaviour. Re-integrative service use was measured by help that was given to assist the person return to the community mainstream and instrumental service use was measured by help given for specific problems in living. The exact distinction used to separate these two types of service use was not further specified and it is possible that significant overlap might be said to occur. Grusky and colleagues provide an interesting and possibly useful way of considering the structural and emotional work that people returning to community living from secure services must do. However rather than counting occurrences of elements of social bonding or indeed seeking to measure them, the possibility of using these categories to conceptualise and investigate community reintegration from the perspectives

of people engaged in such activities could perhaps provide new understandings.

One limitation of this concept of social bonding is the emphasis it places on the individual themselves and the work they must achieve to reintegrate. Some theorists have articulated more systemic concerns about how society is organised to create disadvantage and exclusion of the mentally ill (Lester and Tritter, 2005). One concept that has been applied to the field of mental health as an explanatory model of competing tensions that must be negotiated to enable full community participation is that of social capital.

2.9 SOCIAL CAPITAL

Social capital has been referred to by the World Bank as the

“internal social and cultural coherence of society, the norms and values that govern interactions among people”

(The World Bank 1998: iii).

In practical terms social capital is;

“the existence of community networks based on trust and the use of these networks to enable community action”

(Kelly 2005: 725).

There has been considerable interest in the concept of social capital as an explanatory and functional model in which to address the range of issues 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. Putnam (2000) has suggested that there

are two dimensions of social capital which he refers to as bonding and bridging. Bonding social capital according to Putnam is that which allows the individual to access social supports and reciprocity that reinforces identities, whilst bridging social capital enables wider connections with social actors and hence broader social identities to be achieved.

The explication of social capital and its relationship to mental health is a developing field of knowledge although examples of elements of social capital and its relationship to other theoretical constructs such as structural violence and social bonding are emerging. For example, people leaving hospital and the communities they return to appear to fare better when social support is available (Estroff et al, 1994). A significant source of social support is provided by non-professional informal caregivers such as family and friends. This role of care-giving can be distressing and demanding. It has been found that caregivers themselves experience stigma and discrimination as a result of their association with the mentally ill person (Phelan et al, 1998). Moreover caregivers perceive the communities in which they reside as rejecting, reducing opportunities for interaction with the wider community and denying them the benefits that social cohesion might bring (Struening et al, 2001). As such individuals and their families or caregivers may have reduced social capital leading to increased social isolation and limited opportunities to benefit from wider social networks.

Henderson and Whiteford (2003:506) have sounded a cautious note in welcoming the focus on social capital and mental health arguing that,

“investment in social capital for mental health with an evidence base acceptable for health interventions needs some thought”.

They have expressed the view that further work is required to establish if an association exists between social capital and mental health before policy initiatives move toward public health interventions based upon the concept. Differing views about precisely what social capital is and what it describes have been noted however the conclusion has been that the concept retains

utility for researching the social experience of mental health problems (Almedom 2005).

The accumulation of social capital appears to be an essential element of successful community integration and has particular resonance with more recent efforts to promote and establish what has been termed 'recovery' from mental illness. Opportunities to benefit from social support through access to supported housing or employment have been suggested as ways in which the social capital of individuals rather than society itself may be increased (Sartorius, 2003). These types of social interaction and support are considered to be essential in facilitating recovery from mental ill-health and the consequences of the condition (Hatfield and Lefley, 1993).

2.10 RECOVERY FROM MENTAL ILL-HEALTH

The concept of recovery in mental health is a frequent contemporary rhetoric which has been adopted by policy makers and service providers alike as a potentially useful way of galvanising the broad spectrum of opinion on the thrust of mental health service provision. There is a growing awareness that serious mental illnesses do not have the chronic unremitting progression that has been previously assumed. At their worst these illnesses appear to be episodic rather than persistent and individuals can rebuild their lives and recover. From a service-user perspective recovery is something that people with mental illness do and which mental health professionals can facilitate or hinder (Anthony, 1993). The professional literature suggests a different perspective however. This perspective is that recovery from serious mental illnesses is a possible outcome of sustained comprehensive programmes of evidence-based interventions (Lieberman and Kopelowicz, 2002). These different viewpoints appear to derive from different views on agency. Service-user perspectives of recovery emphasise personal agency as an active ingredient in achieving non-illness oriented identities (Deegan, 1997). Professional literature tends to emphasise bio-medical or bio-psycho-social

approaches delivered by clinicians as being the active ingredient (Davidson and Strauss, 1995).

Despite these different perspectives on outcome there is some agreement about fundamental aspects of recovery. Recovery is concerned with reclaiming a sense of personhood that transcends thinking of oneself as just being mentally ill (Anthony, 1993). Individuals can come to terms with their illness, rebuild their lives and develop new positive identities (Deegan, 1993). Many of these aspects have an existential quality to them and researchers are being challenged to refine these definitions to enable further investigation (Lieberman, 2002). The notion of recovery suggests a transition or rite of passage of social actors moving through stages of the condition and emerging years later from the ravages of an illness that threatens to engulf and destroy their sense of self. Koehler and Spaniol (1994) further elaborate the concept of recovery suggesting that it is composed of two separate elements first, recovery from the illness and second, recovery from the consequences of the illness. The steps that individuals take to address each of these elements will of necessity be varied and will require specific illness-focused strategies as well as broader attempts at social reintegration.

A focus on the identity-relevant aspects of mental ill-health and notions of reforming a sense of self as part of the task of community return are a feature of the recovery literature (Davidson and Strauss, 1992) and perhaps reflect wider concerns about identity and illness (Herzlich and Pierret, 1987). Estroff (1989) has postulated the idea that recovery from the consequences of mental illness labels requires the person to successfully separate themselves, as known internally and as seen by others, from the illness itself. It seems that identity work achieved by people returning to community settings from mental health facilities is crucial in achieving sustained and successful community reintegration. Successful identity performance appears to open the way to establishing recovery from mental ill-health and from the significant effects associated with the consequences of illness. In the next section I

move on to examine identity performance as a constitutive component of talk of social actors.

2.11 IDENTITY, TALK, AND THE SOCIAL WORLD

The literature on identity is diffuse, taking in the fields of health and social psychology, psycho-dynamic psychotherapy and sociology among others (see for example, Strauss 1959/1997; Giddens, 1991; Simon, 2004). This literature sometimes uses terms such as *self* and various descriptive forms of identity such as *social*, *personal* and *perceived* identity as being interchangeable. This appears to reflect notions of identity being a tangible object which is both known internally to the person and enacted externally through interaction. How we see ourselves and are seen by others constitute aspects of identity. These are sometimes referred to as personal identity (how we are known inwardly) and social identity (how we are known by others). As reflexive beings we create identities by distinguishing ourselves from others and by our ability to look at ourselves and have a relationship with our self as an object. Identity is formed in interaction with others. This provides opportunities to determine who we are, how we are known by others and what categories we might claim or have thrust upon us.

These notions of identity and self were perhaps first formally expressed by Mead (1934) who suggested that the self is the conscious part of identity that is not only conscious of the world around it but conscious of itself. He suggests that the self is not only an empirical self (it has intelligence and can think) it also is a social self. This is crucial to an understanding of identity and the self in relation to mental health. Mead's argument was that the self is created through experience developed in interaction with others, the self and the world at large. This then opens the way for the self to experience both negative and positive interaction and the possibility that if the self is considered to be dynamic then it can change for better or poorer outcomes.

Mead's proposition allows that identities will vary over time and within the contexts of our relationships with others and the various audiences we interact with. This notion of identity forming suggests that there is temporal, role and cultural aspects to identity performance. Interaction with the social world is the means to achieve identity work and talk is the means for much of our face-to-face interaction. Language in the form of talk constitutes social practice and is itself produced by social practices (Fairclough, 1989). Social practices involve interaction between individuals to enable the production and maintenance of roles, rules and constructed knowledge. For instance, Hastings (1998) has shown how the use of language in the policy process is linked with social practices such as the construction of knowledge about social reality.

Social practices require a medium for communication and agreement of roles, rules and knowledge. Language-in-use in the form of talk provides the means to achieve this. Talk functions to maintain social order according to Harrison who argues

“language-in-use shapes peoples' social relations, identities and understandings of events” (2006:403).

Talk can be used to great effect to persuade, convince or otherwise construct versions of reality which are accessible and (at least in part) readily and perhaps superficially, understandable by others within interaction. The telling of stories may be one way in which these understandings are made available to third parties. Stories provide an important means of communicating social practices and in particular for articulating and accomplishing identity work.

Mental illnesses such as schizophrenia are joined with identity in both language and terms of reference (Estroff, 1989). Estroff's argument is that serious and enduring mental illnesses such as schizophrenia can be seen as an *I am*, illness; that is it redefines the person as schizophrenic. This can mean that people are seen by others as an illness first and foremost, before being seen as a person, if at all. Diagnosis of a mental illness and how it is

responded to by both the person themselves and those around them have been seen to be important aspects of acquiring identity labels (Hannigan, 1999b). Responses by others can have significant impact upon opportunities for community reintegration as I have previously outlined. People leaving forensic services can be seen as possessing both illness and criminal identities. Some evidence suggests that how the person perceives their own identity is associated with important recovery-oriented outcomes. For instance, Taylor and Perkins (1991) found that people who saw themselves as having a 'community' identity, as opposed to a 'typical psychiatric patient' identity, demonstrated better overall social functioning.

We might assume that the person with a forensic history and a mental illness will have experienced a process in which their very identity is redefined by others, maybe even themselves as they go through the processes of apprehension, incarceration, judicial hearings, detention for treatment and eventual discharge and return to community living. In seeking to build recovery, to leave hospital and reintegrate I have made the assumption that the person will seek to engage in a process of managing identity performances in talk.

Identity performances may be managed in a number of ways, including for instance, through signifiers such as the person's name or through active management in the talk of social actors. In relation to identity-relevant signifiers such as personal names, there is evidence that almost 20% of people in one high security hospital in England had changed one or more of their names at some time, and that they were more likely to do so compared with other psychiatric patients but less likely than non-mentally disordered offenders (Vollm et al, 2002). A follow-up interview study by the same researchers indicated that 31 people who had made name changes only once or twice shared common reasons for example, making or breaking family ties, wanting a fresh start, and difficulties with the name itself (Vollm et al, 2006). Multiple name-changers had more idiosyncratic or 'bizarre' reasons, achieved little satisfaction with these changes and are reported in many cases to have

done so as a result of acute exacerbation of a psychotic illness. Vollm et al, (2006) concluded that changes of name indicated changes in internal mental life and social adjustment.

Another way of understanding these phenomena is that rather than being reflective of some internal state, changing one's name is instead representative of a form of social action that people engage in to facilitate 'passing' (Goffman, 1963: 92). However changing one's name is unlikely to be sufficient in concealing old identities or in establishing newer identities. The challenge is to examine the other ways in which people manage the day-to-day work of identity performance within social settings as conditionally-discharged patients.

One means of exploring how people manage the process of community return is to investigate the talk of people on conditional discharge. Benwell and Stokoe (2006) suggest that we accomplish social action through discourse. How identity is

“accomplished, disputed, ascribed, resisted, managed and negotiated” is through the medium of discourse

(Benwell and Stokoe, 2006:4).

This has resonance with Goffman's (1959) earlier notion of impression management in that through social interaction we seek to accomplish particular outcomes or functions.

2.12 SOCIAL SENSITIVITY

As I have outlined above, people leaving forensic mental health services and returning to community living are challenged by a number of social hurdles that are associated with the consequences of a combined mental illness diagnosis and criminal conviction. In particular this combination of diagnosis

and conviction can suggest particular deviant identities which have profound social consequences. One aspect of identity performance is related to the concept of social sensitivity. Socially-sensitive topics are those which have implications for the individual or the class of people represented by an individual (Sieber and Stanley, 1988). These topics include those which contain an element of risk for the person or are deemed threatening in some way.

Experiences of mental ill-health and related criminal offences may be considered to be identity-relevant, socially-sensitive information. This identity-relevant information is that which the person would rather not reveal and which they actively conceal. Investigating otherwise hidden aspects of social life can present problems for researchers. Social actors may wish to manage what Lee (1993) referred to as threats. These threats can be to participants, their families, elites who exercise power and control or society at large. Lee proposes that, although not inevitably the case, there are at least three types of threat which may be posed by research. These are *intrusive threats*, referring to research investigating the private sphere of participants, *threat of sanction*, which may arise in the study of deviance and *political threat*, which can occur when vested interests of powerful people or institutions are investigated. It is possible that all three threats may exist concurrently. Lee was at pains to point out however that the level of threat is less associated with the precise topic of the research and more to do with the relationship between the topic and its social context.

Brannen (1988) has suggested that where intimate details are likely to be revealed, respondents may have a number of concerns. These include being identified in written reports, the associated risk of sanction and stigma and the stressful nature of confronting and telling personal stories. This has important implications for accomplishing research with populations who may otherwise prefer to remain hidden. It also raises the possibility that where topics are considered socially sensitive the identity performance of individuals will require managing to enable sustained social integration.

2.13 RESEARCHING SERVICE-USERS IN FORENSIC MENTAL HEALTH

Forensic mental health services in line with other health and social care providers are giving increased attention to the views of recipients of care (Faulkner and Morris 2003). There are a number of reasons for this for example, it may help to determine health needs and lead to improvements in quality of life and satisfaction with services (Sullivan 2003). Involvement and collaboration with people who use services may also improve quality of services (Rutter et al, 2004).

Acknowledging the emphasis on greater consumer input to health services and as background to this study, I conducted a review of the literature in this field exploring the range of methods employed, the quality of this research and the views of service-users in contact with forensic services (Coffey, 2006b). This study reviewed empirically based peer-reviewed papers on service-users' views of forensic mental health provision with the aim of;

1. establishing the range of methodological approaches to this topic
2. critiquing methodological approaches used to gain service-user views
3. establishing the range of views from service-users about services

Applied Social Sciences Index and Abstracts (ASSIA), Cumulative Index of Nursing and Allied Health Literature (CINAHL), PubMed, Psych-Info, Sociological abstracts, and Social Service abstracts were searched for material published in English between 1990 and 2004. Search terms included combinations of the words "forensic" and "mentally disordered" with a range of terms used to describe recipients of services including service-users, patients, consumers, survivors, and clients. Papers that did not directly refer to forensic mental health settings were excluded.

This process produced 21 research papers of service-user views (16 UK papers, 2 US papers and 3 Canadian papers). A review paper on service-

user involvement published as a report for the UK Department of Health Forensic Mental Health Programme (Faulkner and Morris 2003) was used as background material. A research report for the UK Home Office that included service-user views (Dell and Grounds 1995) and a user-led research report sponsored by a mental health charity (Rees and Water 2003) were also included in the review. A recently updated version of the review table listing the main aspects of the studies included is appended to this thesis (see Appendix 3).

The main findings of this review were as follows; first, both the volume and breadth of studies exploring service-users' views are limited in respect of the range of approaches to data collection and analysis. Studies in this field used either quantitative methods to collect views of participants or use unspecified qualitative approaches which were in most cases devoid of theoretical underpinning and insufficiently described. Second, studies demonstrated significant flaws in terms of the conduct, application and reporting of the research process. For example most qualitative studies provided only limited extracts of talk from the respondents thus making judgements about interpretation of data difficult to assess. Third, service-user respondents across the range of studies indicated both positive and negative aspects of their experiences of caring and were concerned with restrictions on their liberty as inpatients and as community residents. Most studies focused on inpatient samples and none investigated stories of conditional discharge to the community. Analysis of the talk of respondents was restricted to reporting what was said. In effect this treats respondents as vessels of knowledge by reporting content of talk as self-evident fact (Holstein and Gubrium, 1995). Lastly, given the complexity of ethical issues with largely captive populations, there was a striking absence of discussion on ethical problems in forensic mental health research.

As outlined above few studies have explored the views of people leaving forensic services and returning on conditional discharge to live in the community. One example of just such a focus is provided by Dell and

Grounds' (1995) study of the discharge and supervision of restricted patients which involved examination of Home Office records of those first discharged on conditional discharge (n=183) in the years 1985 and 1986, and an interview study of 46 service-users on conditional discharge and their psychiatric and social supervisors. Information on the theoretical orientation of the interviews and the design and method of analysis is not detailed in the report. The study employed set questions prompted by what appears to have been the funders' agenda (in this case it was the Home Office) and reported interview data were limited to direct quotes from respondents which were presented survey-like under headings related to the main interview questions. It was noted that those agreeing to be interviewed had successfully negotiated return to community living and therefore may have had more positive views about the process. The selection of the sample had excluded service-users who may have re-offended, had been convicted or who were currently re-hospitalised or recalled. Service-user respondents generally viewed conditional discharge favourably and had good relationships with their social and psychiatric supervisors. Respondents expressed concerns about the continuing nature of monitoring and supervision. These concerns included the fear of recall to hospital, the implied threat of recall, the length of time it took to get discharged again once recalled, the effect of the order upon attempts at social integration and the indeterminate nature of the order. Respondents also reported positives about conditional discharge including the amount and quality of support provided and the guarantee of medical help if required. Most of those interviewed (70%) found their contact with professional workers helpful. There was "virtual unanimity" to the general proposition that those on restriction orders be subject to supervision when leaving hospital although a third of respondents indicated that it should ease-off with time (Dell and Grounds 1995:74).

One other interview study of people conditionally-discharged from forensic services was found. This study was conducted by Riordan et al (2002) with a sample of Responsible Medical Officers (RMOs) (n=14) and service-users subject to conditional discharge under their care (n=24). Respondents were

all asked questions on the quality of the relationship, the good things and bad things about supervision and any recommendations for change. The study purports to use a qualitative approach to analyse the data although the precise method is not specified and data analysis is not described. The study reports that service-user respondents valued the practical support and human relationships that resulted from statutory supervision while RMOs valued the legal framework that ensured compliance. Stigma and vulnerability featured in both service-users' and RMOs' responses.

These two studies hint at potential identity challenges experienced by those on conditional discharge. They do not however provide the means of examining how identities are achieved or what forms they may take or indeed how they may shift over time in the transition towards establishing community tenure.

My review established that studies of people's experiences of forensic services are relatively rare and explicit exploration of the talk of conditionally-discharged service-users is non-existent. In terms of community return on conditional discharge the field of study remains relatively new and further investigation seems warranted. The range of approaches to accessing service-user perspectives in forensic mental health services requires expanding both methodologically and theoretically. The application of quality criteria to research of this type should be more consistent and applied more rigorously. A consequence of this lack of attention to quality is that we still know relatively little of the experience and perspectives of people who use forensic mental health services and may judge available findings as unreliable or insufficiently explicated.

2.14 SUMMARY

People returning to community living on conditional discharge from forensic mental health facilities have to contend with levels of scrutiny and supervision

which are primarily targeted at recognising and preventing recidivism through the formalised process of recall to hospital. Thus supervision is predicated on the assumption that the person remains risky in some way and therefore must be monitored and supervised. This may have implications for people on conditional discharge attempting to re-establish viable identities as citizens in the community. Processes of labelling mental illness and criminal offending as deviant are likely to have taken place prompting both workers and service-users to account for and resolve earlier ascribed labels. The labelling of deviancy hints at problems in negotiating the hurdles presented by the organisation of services for mental ill-health. These include achieving social bonding and accumulating social capital although there remains some uncertainty as yet how these processes might be actioned at the level of the individual.

One potentially interesting way of investigating this area is to consider the identity performance of individuals. Talk is a viable form of social action to achieve and manage identities. Attempts to integrate and overcome barriers to successful community living may require the accomplishment of new or revised identities to shake-off the negative effects of labelling. The literature on recovery suggests that successful performances of emerging identities in community living is possible although we have as yet little in the way of developed analyses of first-hand accounts from those directly involved. This may in part be due to the hard-to-reach nature of this population and associated social sensitivities of accounting for mental illness and criminal offending.

2.15 CONCLUSION

This chapter has explored the literature on community mental health care to provide the political and social context for an analysis of return to community living under conditional discharge arrangements. The analysis has addressed the social implications of establishing community tenure in the context of

deviant labels of illness and criminality. These deviant labels were shown to implicate the identity work of social actors who may be engaged in transition towards new emerging identities. Building social capital and addressing issues of discrimination and stigma through greater community integration is dependent upon developing workable new identities. An analysis of identity work as social action achieved through talk has been suggested. However available research on service-user talk concerning forensic mental health services is limited, leading to questions about credible findings.

The analysis presented in this review of the literature will be used in a number of ways throughout this thesis. First, in Chapter 3 the methods used to investigate accounts of conditional discharge are described and defended. My decision to investigate identity work in the talk of people on conditional discharge through the use of in-depth interviews, seeking stories of discharge, is outlined. I outline the concept of narratives as action-oriented talk which can be analysed to examine situated identities produced for the purposes at hand. I also discuss issues of negotiating access, gaining permission and address the not inconsiderable issues of informed consent in vulnerable research populations.

In the subsequent data chapters 4, 5, 6 and 7, this examination of the theoretical literature is used to underpin the developing analysis of talk in research interviews on conditional discharge. This analysis will show how identity work was accomplished in the talk of service-user participants and how workers challenged and at times undermined this work.

CHAPTER 3: METHODS USED FOR DATA COLLECTION AND ANALYSIS

3.1 INTRODUCTION

This chapter discusses the research process for the collection and analysis of data for this study. I present a rationale for the study and its concern with stories of discharge as sites for the production of identity-relevant talk. An overview of the use of first-person narratives in research is presented as a precursor to a discussion of the approach I have adopted. Drawing on ethnomethodological understandings of actors' own orientations and the discourse analysis position of talk as functional, I outline the position I have adopted in focusing upon the collection and analysis of narratives. In particular I address the proposition that stories do particular types of work and can be seen as being action-oriented. Stories as told in research interviews are seen as analysable in terms of the performance of social actions.

I describe the research process that I have engaged in over the course of this study. This included the identification of a hard-to-reach group of people currently being supervised in the community by forensic mental health and social care workers. The two settings providing forensic mental health and social care, and through which participants were accessed, are described.

This chapter will also address my strategy for negotiating and securing local managerial approval to access a group of people who may be deemed vulnerable by virtue of the enduring nature of their mental health problems. I address the considerable ethical and practical issues that were presented by conducting research with people who may be regarded as a captive but nevertheless hidden population. This included formal procedures for gaining local research ethics committee approval. Concerns about capacity to provide informed consent in vulnerable groups are discussed and I describe the approach I took to address these issues. I will discuss the challenges of

recruiting a sample, where concerns about the social sensitivity of identity performance may be significant. Concerns of workers in opening their work to external scrutiny may also be a hurdle to overcome in securing a sample. Access therefore had to be negotiated on a continuous basis throughout the study at both organisational and individual worker levels. I conclude this chapter with an overview of the data chapters that follow.

3.2 RATIONALE FOR APPROACH

As I have indicated the focus of much research with people using forensic services has been on risk behaviours and recidivism. Few studies have sought to investigate what people say about receiving services from forensic mental health teams. The return to community living on conditional discharge requires people to live with significant monitoring and scrutiny of their lives by forensic mental health services. Studies that have examined this area of social life have done so in ways which have not allowed people to prioritise what they say about their experiences and have instead focused on the researchers' agenda (Riordan et al, 2002; Dell and Grounds, 1995). At the outset of this study I had perhaps a naïve notion of giving voice to a seldom heard group⁹. Mishler (2004) has expressed the view that relative to the participant a researcher is powerful and therefore we should not ignore the use of research to further social justice issues. Atkinson and Silverman (1997) have argued that this may conflate a social justice agenda with a research agenda leading to criticisms of methodological naiveté.

My interest at the outset of this research was in what I saw as the missing perspective of service-user accounts in forensic mental health services. This perspective was rarely researched and when it was, it appeared from my analysis to be atheoretical and poorly accomplished to the extent that findings were likely to be viewed as lacking credibility (Coffey, 2006b). Recognising

⁹ In this context I am using the term 'giving voice' to mean providing an opportunity for a socially marginalised group to give their perspective on an aspect of their treatment and care which has been relatively neglected by funders and researchers.

Atkinson and Silverman's (1997) criticism outlined above, and while remaining sympathetic to notions of empowering participants, my approach has been to extend my analytic and theoretical interests to examine not simply the content of what was said but also how talk functioned to accomplish identity performance.

My approach to exploring conditional discharge through analysis of the talk of participants has been informed by Garfinkel's (1967:11) definition of ethnomethodology. This he argued is the,

“investigation of the rational properties of indexical expressions and other practical actions as contingent ongoing accomplishments of organised artful practices of everyday life”.

Antaki and Widdicombe (1998:1) building on Garfinkel's approach have suggested that social life involves “continuous displays” of the understandings of social actors about what is going on and that this is accomplished through ordinary talk in interaction. My approach has been to address participants' displays of understandings as the basis for the analytical claims that I make.

The particular circumstances of conditional discharge in which people are required to submit and comply with continuing aftercare monitoring while living with the threat of recall to hospital suggested to me that social actors must actively address available deviant labels in their talk. I was therefore interested in accessing the perspectives of service-users leaving hospital to examine how they achieved this significant transition. I wished to learn how they achieved transition both physically in terms of practicalities of returning to community living but also more interestingly how they accomplished related identity work in their talk.

I have adopted a practical approach in part determined by difficulties in accessing the talk of a hard-to-reach and relatively hidden social group. Given the limitations on access which I describe below, and what I perceived as the social threats for both service-user and professional worker participants

in allowing access to other forms of talk¹⁰, my strategy has been to emphasise the opportunity to tell the story of leaving hospital.

Telling a story of an experience may be an accessible way for people to talk about past events and to address the range of both positive and negative experiences they have had. It is also one way in which social actors may construct identity performances through talk. I therefore chose to use in-depth research interviews with people so that they could tell their stories. In face-to-face encounters people articulate and account for both their view of themselves and the social world around them. In-depth interviews provide a useful method for people to tell their stories and allow the investigator to follow up areas of analytical interest in the talk of participants. Edwards and Potter (1992:57) note that the intention is to not focus on what 'really happened' but rather on the situated talk that illustrates the social organisation of everyday life as evident in the talk of actors. They also note that establishing what really happened is not an end in analysis, rather the emphasis is on the

“discursive practices of reasoning which the participants bring to bear on this concern”,

when talking about what happened (Edwards and Potter 1992:57). The rhetorical organisation of talk in marshalling attempts at accomplishing truth claims is then one foci of analysis.

3.3 NARRATIVES

Narratives essentially are the stories people tell about themselves and their experiences. They are often located temporally and may be constructed by individuals for explanatory, moral and illustrative purposes.

¹⁰ For example, there is a significant body of work which examines naturally occurring talk in interaction which would allow analysis of identity as situated action. However it appeared highly unlikely from my discussions with gatekeepers that this approach would have been acceptable to frontline workers as it would have implied direct scrutiny of their working practices.

Narratives are seen in some instances to have a beginning, a middle and an end although they can also be episodic and thematic and therefore do not necessarily follow a chronological route (Reissman, 1993). Bury (2001: 281) indicates that personal narratives are a means by which

“the links between body, self and society are articulated”.

Narratives provide access to an important element of social reality in that they are temporal and often indicate the sequencing of past events or imagined future happenings (Gergen and Gergen, 1983).

There is now an established tradition of narrative research in health and social care settings focused on individual experience of health and illness and the resulting consequences for social actors (Kleinman, 1988, Mishler, 1991, Frank, 1995). The focus on narrative and to some extent on the interpretive turn has attracted significant criticism for what is sometimes seen as a neo-romantic view of suffering, for its claims to provide access to the authentic experience of the person and for conflating social justice agendas with decisions on research methods.

Atkinson's (1997) concern with the work of Kleinman, Mishler and Frank is that he sees their claims of access to authentic experience as ignoring the realities of storytelling. That is that story telling is influenced by context, ritual, performance, audience, culture, memory, ordering, motives, moral concerns and interacting. Narrative is one version of experience and its validity stems not from any claims to access some embedded singular truth but rather from the point that it is issued by one protagonist, in the story – it is as valid as other versions but not more so. Atkinson (1997:333) argues that the “biographical warrant” of narrative does not provide a hyper-authentic version of actors' experiences or selves and that such a claim is a distraction in that it directs attention away from what actually may be of interest in stories. In Atkinson's view once we accept that stories are influenced in the ways described above then this opens up for analysis the practices via which narratives are achieved and the work they do in the talk of social actors. Talk

has particular functions and analysis of its structure, sequence and focus may reveal details about the social purpose at which talk is directed and how it achieves its tasks.

Narratives are one way in which persons articulate views on events in their lives, how they orient towards particular occurrences and the work that they are warranted to do. Analysis of talk in the form of narratives can provide new understandings for health and social care professionals seeking to support community return and recovery. For instance, deviant identity labels are warranted in social situations where illness and criminal offending occur. In such circumstances social actors are required to account for these labels and participate in new identity work through the medium of talk in interaction. Story telling is one way of achieving this work and enables social actors to do the work of accounting. Narratives therefore have a social function enabling the person to articulate versions of their experience and in doing so communicate oriented-to identities.

In much health and social care research it has been argued there is an over-reliance on the interview as a method of data collection (Silverman, 1998). One limitation of the use of interviews is that accounts are often presented as illustrative of the internal world of the person or that a single meaning can be attached to people's experiences of the social world (Nunkoosing 2005). There also appears to be an assumption that we can determine motivation and attribution from what people tell us in their talk. Bury (2001) suggests that an awareness and analysis of the motives behind narrative accounts and the context in which they exist is required rather than simply taking these at face value. It is also likely however that people may attach different meanings for the same event and for different audiences. Rather than treating analysis of talk as an opportunity to discover internal psychological understandings of social actors an alternative is to view talk as situated, produced for the purposes at hand and functional (Antaki et al, 1996).

One example of the functional nature of talk can be seen in the use of rhetorical devices. Edwards (1998:16) notes that all discourse is pervasively rhetorical in that it orients towards alternative ways of describing things. Talk seeks to agree, persuade, argue or challenge and therefore a focus on the content of talk as a means of understanding what experiences mean is insufficient, we must also consider what the talk is doing. Edwards (1998) like others at the Discourse and Rhetoric Group at Loughborough University (Radley and Billig, 1996), rejects the notion that talk is somehow illustrative of internal events, that is that we can know what someone is thinking and their motivation by analysis of what they say. Rather he suggests that the internal world (cognitions) of the person is not available to us to interpret and analyse. What is available is the talk of the person and what talk is used to do. It is this focus that has informed the current study and the resulting analysis of interview talk. This is not to suggest that I am rejecting the notion or theory that talk may be illustrative of internal psychological processes. I have however taken the position that I cannot know these as they are not available to me through the interview talk I have collected.

One way in which stories have been examined has been to adopt a structural approach to explore common parameters of spoken narratives. Labov and Waletzky (1967) describe a structural method of segmenting transcribed narratives into abstract (summary of the substance of the narrative), orientation (time, place, situation, participants), complicating action (sequence of events), evaluation (significance and meaning of the action, attitude of the narrator), resolution (what finally happened) and in some cases a coda (returns the perspective to the present). However, Riessman (1993) suggests that this framework may not be directly applicable to all narratives and may therefore need adaptation.

Analysing talk in narratives in purely structural terms can present a number of limitations. First, not all talk may be produced in a narrative form and reconstructing a narrative from the talk of individuals with choice selections of interview transcripts would seem to privilege the researchers' perspective

above that of the speaker. Second, applying various structural typographies to a series of interview-based talk is unlikely in isolation to be illuminative. It will reveal how certain types of narratives are structured but perhaps little else. Analysis must go further to examine how stories are accomplished in talk, what functions they might be serving, what work is done by the telling of the story and what this may then tell us about the work actors are required to do in social situations.

Stories are told to fulfil social functions and analysis must attempt to discover these. They also engage hearers in particular ways so that they are prepared to hear particular types of stories and less so other types of stories. As Reissman (1993:18) states

“Different genres persuade differently; they make us care about a situation to varying degrees as they pull us into the teller’s point of view”.

We might therefore view narratives as the ways in which people articulate their view of themselves and their place within the world. They are illustrative of the type of identity the person orients towards.

I have taken the position that narratives are purposeful and situated: that within the interview context they offer an occasioned account which achieves particular functions such as orienting towards particular identities. Edwards (2006) refers to this way of analysing talk as ‘action-orientated’.

I have taken the view that interviews aimed at encouraging narratives will help people tell their story in their own words, prioritising what they wish to say and the way in which they say it. I see the talk produced for these interviews as being for the purposes at hand, that is for the interview in which they are asked to tell their story. I do not see interviews as providing unique access to authentic life stories that are only available through this method. I have treated interview talk as not purely telling it like it is or was, as not being indicative of how the person sees the world or what they believe. The talk is instead doing something; it is performative and action-oriented (Searle, 1969).

People use talk to convey messages of identity, persuasion, sincerity, excuses, motive and confession. Talk in interviews whether in the form of narratives or otherwise is produced in an interactional setting and can be rhetorical in that it manages competing accounts. It is not however naturally occurring conversation and the analysis of talk in interviews must therefore acknowledge this.

Not all narratives are presented as complete stories, some are fragmented and the researcher must attempt to follow a thread through a series of spoken responses to elucidate the narrative. For the purposes of utility and rather than to disregard some talk because it fails to follow a narrative path or structure, I have taken the view that all talk is purposeful and oriented towards particular motives, explanations, moral positions, identities and other types of functions. As such I have treated all utterances in the interview talk as available for analysis.

The approach has been to examine at least two separate elements in the data. This is first, the analysis of content of responses focusing on the process of discharge and distinguishing the staging of this process in the talk of respondents. Second, the analysis involved an examination of spoken responses to investigate what the talk was working to achieve. The context for this interview talk is one of discharge and return to community living and the process of discharge itself is the basis for the production of these accounts.

3.4 RESEARCH PROCESS

3.4.1 Why In-depth Interviews?

In the current study I have taken the pragmatic decision to conduct in-depth interviews with people on conditional discharge and those supporting them in their return to community living. This is for a number of reasons. My interest was in hearing first-hand accounts of the experience of community return on conditional discharge to examine what people say and how they say it. I see

talk as one way in which we construct the social world. My position is that talk is used to achieve orientation towards personal and social identities by social actors. In doing so talk addresses culturally available information about individuals and the social situations in which they find themselves. I see talk in stories as illustrative of the social interaction work people must do to enable successful return and recovery.

Interviews provide an acceptable method of accessing this talk in what is a hard-to-reach group of service-users who may be attuned to social sensitivities surrounding their previous activities. This group have rarely been studied in ways which allow in-depth first-hand accounts to be gathered. My intention was to also gather data in the form of spoken accounts or stories from professionals and carers who provided support to the person on conditional discharge, to examine the ways in which these supported or challenged service-user accounts. Interviews again provided a reasonable means to do this. This type of data is not available in any other form. Observation of community living and interaction between carers, professionals and the person on conditional discharge would not have been feasible due to the heightened sensitivities associated with this population. Analysis of clinical records may be revealing about professional practice but these are unlikely to communicate the perspective of the person on conditional discharge or indicate identity work in talk. Written accounts perhaps could have been elicited but I felt more comfortable with the immediacy of the face-to-face interview method.

This was largely because as a former practicing psychiatric nurse in this field I hold a firm belief in my potential to establish rapport, build confidence and provide a space for people to tell their stories. Mental health nursing more generally has aspired to achieving the humanistic imperative or core conditions as part of establishing helping relationships with people with mental illnesses and I have seen these values as an important part of my professional life (Hewitt and Coffey, 2005). I saw interviews as an acceptable approach to data collection that matched some of my previous skills.

Interviewing however is not to be taken on lightly and the concerns expressed in the literature about interviewing are relevant for all researchers regardless of their previous background (Atkinson and Silverman, 1997; Silverman 1998; Nunkoosing, 2005).

Parr (1998) provides an interesting critique of Pile's (1991) suggestion that the research interview can make use of psychoanalytic theory as a means to aid data generation. Pile's position appears to argue for a research alliance that is analogous to the therapeutic alliance in that it is aware of issues of transference and counter-transference thereby enabling deep understanding to take place. Parr (1998) notes that in some circumstances research interviews can be seen by both researchers and respondents in therapeutic terms and that this may bring with it both advantages and disadvantages. Despite my stated orientation towards helping relationships this was not the approach that I intended to take. This was for a number of reasons. I did not wish to confuse or conflate my chosen method and its purpose with that of the usual clinical encounter. My view is that this runs the risk of blurring the boundary for participants between the purpose of the encounter and my role within it. Moreover this notion of an analogous research alliance assumes that the achievement of this alliance is uncomplicated, easy to establish and can be adopted with only minimal effort to establish the necessary skill level.

Research interviews may have therapeutic benefits but they are not therapy and the issue for me was to manage expectations of myself and others within the field with regard to notions of the research interview as a mirror of more familiar therapeutic or clinical interview settings. By this I mean that in the interview setting I wished to present as a researcher interested in hearing stories for the purposes of data collection and this required that I monitored myself to prevent slipping into nursing mode and offering intervention or advice on mental illness or problems in community living. This was not always easy and even when I believed I had become a more accomplished

research interviewer I still found it necessary to keep in check my desire to offer helpful responses.¹¹

The telling of a story in a research interview requires both a teller and a listener and both parties are active and influence the type of story that gets told and the ways in which it gets told. This idea of co-construction is evident within the work of Mishler (1991) who made the point that attempts to conduct hygienic or even sterile interview research has failed to reconcile the problem of using a standard format to attain neutrality (with the aim of achieving between-interview comparability) with developing individual rapport which by definition will be non-standard and possibly lack comparability. Mishler (1991) suggests the dominant concern to provide a form of perfect laboratory environment in which all factors are controlled for conceals more fundamental problems with standard research interview practice. Here Mishler is alluding to his preferred focus on narrative and the reflexive interviewer who demonstrates an awareness of his/herself, the position he/she holds with regard to the respondent and the context of the interview itself. For Mishler this very reflexivity is a resource to enable rich in-depth understanding and can assist with developing the participants' account.

The notion of co-constructed accounts has been further developed in Holstein and Gubrium's (1995) idea of active interviewing in which the process of interviewing and developing the narratives of participants acknowledges the interviewer's role with the aim to make this transparent through reflexivity. One concern of mine has been how to best represent the contribution of myself and the participant in the account that is offered. Silverman (2000: 35) further elaborates the view of Holstein and Gubrium by indicating that we should view the researchers' questions as part of the process in which

¹¹ I recognise the problems associated with insider/outsider dichotomies in research settings (Allen, 2004), although I have chosen not to explicitly develop the discussion here. During this study I was often aware of my previous identity as a forensic nurse. This came into play during negotiations to secure access to the settings and during individual research interviews. It was clear to me that at times there was available everyday understandings related to this identity at play in these interactions. On other occasions my outsider status was made relevant by gatekeepers and street level workers, particularly in relation to securing a research sample. I discuss some of the issues involved in gaining access to the research population later in this chapter.

narratives are assembled. This is because questions or prompts from the interviewer occasion responses in interviews and therefore represent an important part of the construction of the account. I have attempted to resolve my concern about my contribution to the stories told by participants by transcribing and including the questions posed as the interviewer and by reflexively acknowledging the context of the interview within the written analysis.

3.4.2 Field Notes/research diary

Silverman (2001) has suggested that maintaining a research diary will enable the researcher to recall important decisions, aid reflection and help chart the development of thinking over the course of a study. I have kept a research diary from the period prior to registering for doctoral study and throughout the field work and writing up of this thesis. Silverman also suggests that this will help in writing up the methods section of the thesis and to an extent the availability of a timeline of events, major decisions and analytical thoughts have served this purpose well. The distinction between what is a research diary and what might be regarded as field notes have for me become blurred at times during the research. Field notes provide an important source of analytical material in ethnographic research although it is sometimes less clear what they should include and how to make use of them. Emerson et al (1995:11) have noted that while there is no one way to write field notes they should

“give special attention to the indigenous meanings and concerns of the people studied” and “give essential grounding and resource for writing broader more coherent accounts of others lives and concerns”.

The current study while not an ethnography is ethnomethodologically informed in that it is concerned with social actors, their social lives and the everyday understandings that are accomplished through talk.

My research diary has taken the form of field notes at times but it does not seek to achieve the form or substance that Emerson and colleagues allude to as being necessary for ethnography. Instead my research diary has been a record of key decisions, problems, reading, discussion, research interviews, interaction with gatekeepers and potential participants, research supervision, interaction between other interested colleagues and emerging thoughts about the data. I have attempted to keep contemporaneous notes of meetings, interviews and contacts with potential participants and gatekeepers as one way of tracking the process of the study and to collect ideas and thoughts that might inform later analysis. Its usefulness has been particularly reinforced for me as a part-time student when it becomes necessary to pick up threads and rediscover conclusions and courses of action following a period away from the study. My understanding of the audio-recordings has been greatly enhanced by these notes of encounters within the research settings. Nevertheless I have found at times that my notes have not been as inclusive or as comprehensive as I would have liked and perhaps this reflects the pressures of attempting part-time study over a number of years within the context of a busy academic teaching role.

3.4.3 Research Settings

This research was conducted with clients and staff contacted through two National Health Service settings which provided forensic mental health inpatient and aftercare services to the population in one region of Wales. These settings were chosen as they delivered a range of services to people discharged from mental health services under Home Office monitored conditions. This included both the preparatory stages of discharge and aftercare monitoring and supervision immediately following return to community living. These services were relatively local (within 50 miles) and therefore reasonably accessible and had both regional and local administrative responsibility for the aftercare of the majority of people subject to conditional discharge within the geographical region. These settings were then the focal point for access to both service-user and professional participants. Given that repeated visits to the settings to secure access was

necessary and that further repeated visits to conduct data collection would be required these services provided the most practical option for securing the required samples for participation.

Setting one was a NHS forensic regional medium secure setting and provided services to men and women in a defined geographical catchment area.

During the study period this service moved to a purpose-built modern building increasing the number of inpatient beds in the process. The community aftercare services were primarily delivered from staff based in offices in this building. Most of the aftercare services were provided by forensic community mental health nurses and approved social workers acting as social supervisors of aftercare under Section 41 of the *Mental Health Act 1983*.

The nursing and social work teams experienced some changes in personnel over the course of the study. However for the most part they consisted of five community mental health nurses and five approved social workers providing aftercare and support to people discharged from inpatient care. The community mental health nurses shared a large office and had the most frequent contact, often weekly with the discharged person. Nursing input to people discharged from inpatient care included administration of medication, psycho-social type interventions such as relapse planning and monitoring of mental state and risk status. Nurses, unlike their social work counterparts do not have formal reporting requirements to the Home Office in relation to conditionally-discharged people but contribute informally to these reports through team meetings and documenting visits through case notes and contact sheets.

The social workers were based across the corridor from the nurses. Social workers often visited the conditionally-discharged person with the nurse but on a less frequent basis. The focus of their work was on the role of social supervision which is part of the statutory requirements for supervision and monitoring of conditionally-discharged people (Mental Health Unit, 2007). It included assessment of the person within their social systems and the

influence of these social factors upon risk status. This work would often commence when the person was first admitted to the inpatient service. Social supervisors are required to provide written update reports to the Home Office on a three monthly basis outlining such things as the person's social supervision, the level of compliance and changes in risk status since the last report.

Medical aftercare ranged from monthly to three monthly outpatient appointments and was provided by four consultant psychiatrists fulfilling the role of Responsible Medical Officer (RMO) under the *Mental Health Act 1983* (Mental Health Unit, 2006). This required the RMO to provide three monthly update reports to the Home Office on the progress and aftercare of the conditionally-discharged person. The RMO was responsible for the psychiatric treatment of the individual which in most cases included psychotropic medication and where necessary admission to hospital for further assessment and treatment. Being based in a medium secure service the aftercare teams also had access to the range of professional resources that these services employ. Clinical psychologists, occupational therapists and the availability of secure inpatient services were therefore sometimes used as adjuncts to the aftercare of people using the services.

This setting provided an array of forensic mental health services as envisaged in the *Reed Report* (DoH/Home Office 1992). This consisted of criminal justice liaison and custody diversion, providing services to the prison population and transfer of prisoners requiring inpatient care, providing an interim stage in discharge from high security hospitals, assessment prior to court appearances and sentencing as well as rehabilitation, preparation for discharge and eventual aftercare.

Setting two was a forensic community outreach team consisting of forensic community mental health nurses, social workers, psychiatrists, psychologists and occupational therapists. The majority of aftercare and supervision was however provided by the nursing and social work staff. The team was based

in a large Victorian mental hospital and had their offices in what was formerly the nurses' residential block. This team had access to what was termed 'low secure' inpatient beds on a ward in the same hospital. Low security is essentially a locked facility within a large psychiatric hospital but without perimeter fences or double airlock type doors usually found in medium secure services. Setting two had no direct access to medium secure inpatient services and most of the people for whom they were responsible were returning to the area from other secure services. This included high security services and both public and private medium secure services. Private medium secure services are independent hospitals that provide services on a contractual basis for NHS and social care agencies that have insufficient local resources to place people.

This local forensic team shared some of its catchment area with the regional team in setting one and an uneasy alliance existed between the two teams. People already discharged and living in the community within the geographical patch of this team would have their care passed on from other NHS teams following an agreed period of time to allow the person to settle out of hospital. However in the case of the private medium secure services the immediate involvement of the team in follow-up and aftercare was necessary as this contracted service did not include aftercare provision.

Community mental health nurses in setting two were employed and directly managed by the local NHS Trust. Social workers fulfilling the role of social supervisors although based in the same premises were employed and managed by the local authority.

3.4.4 Negotiating access to settings

The process of negotiating research access to a hard-to-reach population such as in forensic mental health settings can initially appear insurmountable. In the early stages of this study I was anxious to gain access, to develop relationships and use available contacts that would facilitate access. The challenge lay in negotiating an approach that allowed gatekeepers to have

confidence in the conduct, purpose and outcome of the research. Negotiating access to both research settings commenced prior to seeking Local Research Ethics Committee (LREC) approval. This was for two reasons. First, the LREC application would be strengthened and the research proposed could be judged as achievable if I could reassure the committees that I had sought the advice and co-operation of senior gate-keepers in the study settings. Second, if access could not be secured I would be wasting not only my own time but also the time and resources of the LREC by applying prematurely for ethics clearance. The work of negotiating access commenced in Spring 2002 and continued throughout the study until data collection ceased in the Summer of 2006. Negotiating access is not a one-off occurrence and throughout the field work access had to be continually re-negotiated at multiple levels (Shaffir and Stebbins, 1991; Lofland et al, 2006).

Forensic mental health professionals are, like their colleagues in the wider health service, acutely aware of the potential for negative media attention (Huang & Priebe, 2003). Workers are attuned to the potential for intrusive and voyeuristic interest in the histories of those receiving services from forensic mental health teams. This makes access to this group highly complex. In effect they are guarded against unnecessary intrusion from the media and the public by services that are alert to preventing unwelcome publicity. This may be one consequence of a culture which historically encouraged secrecy by compelling high security services staff to sign the Official Secrets Act (Kirby, 2000). It is however also the case that these services have a growing awareness of their proximity to local communities, are sensitised to notions of risk and the potential for negative media interest to complicate the work of caring for and rehabilitating people with mental health problems and criminal convictions (Berlin & Malin, 1991). Researching otherwise hidden aspects of social life may give rise to concern for researchers and practitioners alike when there is a possibility of media interest inaccurately translating research findings into news (Channels, 1993). Researchers (and particularly those researchers originating outside the host organisation) seeking to investigate forensic mental health settings are likely

to be subject to scrutiny by gatekeepers to ensure that the goals of the proposed research are consistent with the organisation's aims.

Dingwall (1980) refers to the notion of hierarchies of consent existing in settings which are formally organised. It can be assumed that superiors can permit subordinates to be studied, although in effect the permission only realistically extends to initial access to the target population who can then choose to consent or otherwise. Shaffir (1991) has argued that subordinates can disregard gatekeepers' approval or rejection, and will make their own judgments about participation in research. In formal settings such as the health service however it remains very difficult for subordinates to fully disregard management decisions. Consent given at the top of a hierarchy does not always transform into co-operation at lower levels in a setting. Staff may not be permitted to refuse to participate but can choose to withhold full co-operation or create obstacles to restrict access to others in the setting. Physical access to staff may not be accompanied by social access and fronts may be used to deter examination of practice. Indeed consent offered towards the bottom of the hierarchy may be tokenistic and the researcher will then have to contend with impediments such as "concealment, obfuscation or deception" (Lee, 1993: 133).

The levels of consent that must be addressed to gain access to a population have to be negotiated differently and with a view to the possible sensitivities that are likely to hold in the specific setting. In this study each setting presented its own challenges although there were similarities in the stages of access.

At least three stages of access manifested in field work for this study. These were;

- * at *management level* – here I am referring to the administrative and formal mechanisms of gaining permission to approach members of staff or securing support in principle to researching the setting,

- * at *street level* – here I am referring to staff on the front line delivering services and securing their co-operation and willingness to help with the research, primarily in identifying potential participants on their caseloads, and lastly,
- * at *participant level* – here I am referring to the process of gaining consent and participation of service-users and front-line staff who met the study criteria.

Access to the study population moved through stages which initially at least seemed to be sequential. For instance at the *management level*, approaches to senior managers and senior clinicians was required to achieve access to the study settings. This involved both formal meetings with senior staff to discuss the research and opportunistic informal approaches where for instance I was introduced to other decision-makers who share office space. This task had to be repeated as more than one setting was accessed over the course of the study and even within settings as management structures shifted. At *street level*, multiple group and individual meetings with front line staff were necessary to advertise the research, provide reassurances and secure co-operation. In total I attended ten separate meetings across both settings to negotiate access and secure support for this study. At participant level it was necessary to provide reassurances particularly to service-user participants regarding the focus of the study. In many instances this was directly related to concerns about re-telling events surrounding the index offence and potential participants required reassurances that I was independent of those providing services and would maintain confidences.

3.4.5 Research governance

Research on forensic mental health services has to balance the intent to include service-user responses while contending with a range of ethical problems. For instance, many people receiving services are detained in secure facilities or living in the community and liable to recall to hospital effectively placing them under the control and scrutiny of workers.

In England and Wales the research governance framework has been steadily evolving in efforts to standardise and centralise the process of ethics application and clearance for research on staff and recipients of health and social care. This guidance has continued to develop over the course of the current study. At the time that ethics clearance was sought for setting one (2003) and setting two (2004) it was necessary to make separate applications to each Local Research Ethics Committee (LREC) and to follow separate procedures for permission from the local authority for research with social services staff and Research and Development panels at the participating NHS Trusts. This required me to make four separate applications for research clearance, two for ethics clearance and two for organisational research governance clearance.

An important element of these applications was my intention to conduct research with people still subject to a formal section of the *Mental Health Act 1983* and who might be considered to be a captive audience. Section 41 of the *Mental Health Act* is the provision which restricts discharge from hospital of people convicted of serious offences and detained for treatment of a diagnosable mental disorder. In most cases discharge from hospital is conditional upon agreements to continue to accept treatment, to reside in a place specified and to attend for appointments and treatment. Additional conditions can be set by the Mental Health Review Tribunal or the Responsible Medical Officer and can include restrictions on travel, curfews and directions to not approach specific individuals such as the victim or their family. A breach of these conditions or a conclusion that the person is not complying with them may lead to recall back to hospital regardless of assessments of deterioration in the mental health. This can mean that the person is sensitised to complying with the wishes of workers to the extent that concern has been expressed about how in such circumstances potential subjects can withhold consent to participate in research (Adshead and Brown, 2003).

An associated concern, given that this population of service-users were likely to have serious and enduring mental illnesses, was how judgements would be made about the person's capacity to provide informed consent to participate in the study. The body responsible for safeguarding the interests of those detained under the *Mental Health Act*, The Mental Health Act Commission (MHAC) has provided guidance on the participation of detained patients in research (MHAC 1997). Its conclusion was that although principles cannot always be held to apply to all situations the participation of detained people in research should not be prevented while the person has capacity to give informed consent. The Commission articulated two exceptions to this position that should prevent participation, these being; involvement in research that conflicts with provisions of the *Mental Health Act 1983* or involvement in research that is inconsistent with treatment being received. To address these concerns I made clear my intention in my ethics applications that I would have no contact with service-user participants prior to their decision to participate other than through the information sheet for the study. The proposal also indicated that the Responsible Medical Officer would then to be approached for advice on capacity and participation decisions with regard to service-users who had indicated a wish to participate in the research.

I applied to Iechyd Morgannwg Health Local Research Ethics Committee in Spring 2003 for permission to research in setting one. The committee met once monthly and I was invited as was customary at the time to attend the meeting and present my research proposal to the committee. It was also the practice at this meeting for other researchers who had applications being considered to be present throughout the whole meeting. The focus of concern of this meeting was less on the ethical implications or design of the study and more on issues of researcher safety. The committee were concerned that I was planning to visit and interview people alone in their own homes. The impression was that the participants had proven themselves to be dangerous people and this could place me as the researcher at risk. My reassurances about this being standard practice in community mental health services went somewhat to allaying their fears. I also emphasised that I would

abide by the lone worker policies of the settings and report my whereabouts to clinical staff. The approval letter from the LREC emphasised that they wished me to adhere to this intention.

I applied for ethical approval for setting two to the Bro Taf Local Research Ethics Committee in Spring 2004. This committee met twice monthly and I attended the meeting to answer queries regarding my proposal. The committee required some re-ordering of the paragraphs on the information sheet for participants. The committee queried my decision to collect demographic details of the sample. The decision to collect some limited background information on participants was to allow the sample to be described and to aid transparency by permitting comparison with other studies in the field and this explanation was accepted by the committee. The approval letter from this second committee was concerned primarily with version numbers on information sheets and consent forms but also included a reminder to seek NHS Trust research governance approval.

This subsequent process is part of the research governance framework in the NHS and required me to secure an honorary staff position in the organisation. This required a number of formal and informal meetings with senior managers and clinicians. A further research application was then necessary to this panel requiring evidence of the honorary position, signatures of research leads in the organisation and consideration by the Trust risk assessment panel. Finally an additional application for research clearance was required to the local authority research panel in setting two when it became clear during the course of the study that social supervisors in this setting were not NHS employees and that I required this additional clearance. This application required that I submit my research proposal to the local authority research manager and undertake to abide by standard principles of research governance such as secure maintenance of data, seeking informed consent and respecting confidentiality of participants. Both the LREC and the NHS Trust research governance panel in setting two continued to require annual reports on the progress of the research after approval was granted.

3.4.6 Capacity to Consent

People with mental health problems can be seen to lack objectivity in determining the appropriateness and quality of care they receive (Lebow, 1982) leading to a reluctance to seek their views. Conducting research with this group of service-users has given rise to concerns about capacity to give informed consent, the validity of consent when detained, issues of control, power, privacy and confidentiality with the potential for exploiting for research purposes a literally captive audience (Adshead and Brown, 2003).

“Capacity” can be defined as the ability to exercise autonomy and independent decision making. The *Mental Capacity Act 2005* (DoH and DCA, 2005) indicates that in law there is a presumption of capacity, that is; a person is assumed to have capacity until it is demonstrated otherwise. The Act also recognises that a person’s capacity may fluctuate and be related to one matter and not another. Mental illness is one area where it can be argued that capacity may be said to be impaired or disturbed either temporarily or long term. People may therefore be seen to have impaired capacity regarding treatment decisions for their condition but not in relation to decisions to consent to participate in research.

Serious and enduring mental illnesses can affect the person’s cognition and understanding and lead to reduced concentration (Coffey, 1998a). These conditions however are recognised to be episodic in nature (Zubin and Spring, 1977) with periods of remission and improved functioning. As such it has been noted that people with psychiatric conditions are capable of comprehending and giving informed consent to participate in research (Carpenter et al, 2000; Pinals et al, 1998). Further it has been found that mental illness does not preclude people from offering clear, coherent and balanced perspectives on the services they receive (Lidz et al, 1995; Hoge et al, 1998).

External scrutiny via a research ethics committee is an important safeguard against prurient, voyeuristic and exploitative research with patient populations.

The research proposal and application to both LRECs therefore paid due attention to these concerns and addressed the Mental Health Act Commission guidance directly by proposing to request Responsible Medical Officer opinion on the capacity of individuals to provide informed consent.

Service-user participants were approached to participate in this study by the nurse or social supervisor working with them who offered an information sheet on the study (see Appendix 4 for information sheets used in this study). This explained the purpose of the study, that participation was voluntary and that participants were free to withdraw at any point without consequence to their care and treatment. Potential participants were asked to contact me directly or to do so through the nurse or social supervisor to indicate their interest in participating.

A minimum of two weeks was allowed to pass between participants expressing an interest in participation and meeting to conduct the research interview. In all cases Responsible Medical Officer opinion on capacity to provide consent was sought and secured for each service-user participant. Prior to each research interview I explained who I was, the purposes of the research and checked that participants understood this before agreeing to participate. Written informed-consent was obtained from all participants prior to interview (See Appendix 5 for consent forms).

3.4.7 Recruiting the sample

The study consisted of twenty-two in-depth interviews with twenty service-users¹² on conditional discharge on Section 37/41 of the *Mental Health Act 1983*, nineteen interviews with their social supervisors (n=10) and eighteen interviews with CPNs (n=10). This total of fifty-nine interviews formed the material for analysis. All interviews were first arranged with the service-user and once this was completed CPNs and social supervisors working with the

¹² Two service-user participants preferred shorter interviews because of other commitments and requested a second interview and where therefore interviewed twice.

person were approached to participate. The approach was to prompt respondents to tell their stories of discharge and follow-up aftercare.

The decision in this study to seek a purposive or theoretical sample was guided by the purpose of the study. The study inclusion criteria included; men and women (over the age of 18 years) with mental health problems and experience of recent or prolonged conditional discharge. The aim was to gain a sample of respondents who would speak about recent experiences of preparation and return and also those who had had a sustained period of community living since their discharge. It was hoped that this strategy would enable a range of stories to be told and make it possible to observe the management of identity in talk at different phases post-discharge.

An initial minimum threshold target of ten service-user participants and nurses and social supervisor interviews was set and then revised as the study progressed. This was because it became clear during the early recruiting stage of the study that the sample appeared in some ways to be atypical of the range of people provided with aftercare by forensic mental health services. That is a number of those interviewed were older retired men with recent history of common mental illness and short stays (under two years) in forensic in-patient settings. Home Office statistics have consistently indicated that most people detained on Section 37/41 are men with serious and enduring mental disorders and that 90% are between the ages of 21 and 59 years (Howard and Christophersen, 2003; Home Office 2007). As this became clear a decision to persist in data collection beyond the minimum threshold target was made. One result of this was that recruitment of the sample continued over a three year period to attain the final sample of twenty service-user participants. This included younger people with longer histories of enduring mental illness and longer periods of detention in secure settings.

A pragmatic decision to stop recruiting to the study was made when the sample of service-users had reached twenty. At this point fifty-nine interviews in total had been conducted and transcribed over a three year period (2003 -

2006) and in addition to those known to have declined¹³ to participate it seemed unlikely that many new participants could be recruited. The sample of twenty services users spanned the age range from young adult to older person, included men and women, employed people and unemployed and those with a range of mental health problems and criminal convictions. Details of the sample are summarised in a table in Chapter 4. A rough estimate suggests that this sample represents approximately 40% of the total number of people subject to conditional discharge and aftercare within the two settings during the study period.

CPNs and social supervisors providing aftercare and follow-up were approached for interview following completion of the service-user interview. Professional workers were identified either as result of them identifying themselves by suggesting potential participants, or through being mentioned by service-users during research interviews.

I had planned that family members and informal carers would also be included, but without exception this proved impossible. Some service-users had no informal carers or had lost contact with their families, some refused access outright while others failed to deliver the contact details as promised. I have not been adequately able to explain this. In many cases family details were promised by participants but ultimately were never provided. I adopted a policy of reminding¹⁴ service-user participants once by letter that I remained interested in hearing stories from family members but without exception no details were provided.

¹³ I know of 9 potential candidates who declined to be interviewed, they are listed in Appendix 8 and where reasons were offered I have made a note of these.

¹⁴ There seemed to me to be a fine line between assertive follow-up of non-respondents and undue pressure or harassment. Where participants indicated at interview that they would be happy for me to approach family members I sought to get these details there and then. However in all cases participants indicated they wished to first check with their family or carers. In these circumstances I allowed two weeks to pass before sending a reminder letter and determined that no response at this point was as good as a refusal.

3.4.8 Nature of the interviews

Service-user participants were offered the opportunity to be interviewed in whatever setting they felt most comfortable and most interviews took place in their own homes. In each instance I introduced myself, explained the purpose of the study and ascertained that they understood I was conducting research and were prepared to offer their consent to participate. All interviews were recorded on a digital voice recorder for later transcription and notes were also kept during the interview to aid this process. Interviews with nurses and social supervisors were for the most part conducted in their places of work. The one exception was one nurse who chose to be interviewed at the University.¹⁵

All the service-user interviews commenced in a similar fashion, that is with a request to participants to tell their story of preparation for discharge and eventual return to the community. A prompt sheet was developed to be used in the interviews covering a range of issues related to community integration and social supports (see Appendix 6). These prompts were largely based on the work of Grusky et al, (1985) who proposed a theory of social bonding and community adjustment in relation to the return of mentally ill people to the communities from which they originate. A variation on this approach was used for professional worker respondents who were asked to tell their stories of involvement in the preparation, discharge and aftercare support of the named service-user participant.

The broad categories of community adjustment suggested by Grusky et al (1985) were reconfigured as prompts for the interviews with all participants. In part this was to address my concern to ensure that comprehensive coverage of the range of topic areas was achieved within individual interviews. Over the course of the study however this anxiety proved to be largely unfounded and most participants did not require prompting to address aspects of their return to community living. Moreover I learned to relax and

¹⁵ This participant had a previously arranged appointment at the University and felt it would be more convenient for him to see me on the same day than to arrange another time during his busy working week.

allow participants to foreground material in their accounts that were relevant to them without the external application of prompts that felt artificial and cumbersome when invoked in the course of the interview.

It is possible that recounting previous experiences in a research interview setting can lead people to recall upsetting or painful life events that they might wish to forget. The approach adopted in this study was to ask about preparation for discharge and eventual return to community living. However all service-users participants had been convicted of serious offences, had suffered enduring mental ill-health and had been detained for periods in secure settings as a result of this. The precise detail of their offences and illness was not known to me as the researcher and during the interviews I did not seek this information as it was not directly relevant to the focus of the study. However some respondents chose to tell this part of their stories during the interviews and while this was not foreseen I made no attempt to prevent disclosure. Instead I decided to treat this talk as situated and produced for the purposes at hand, that is I saw it as achieving particular functions within the story.

Participants were told at the beginning of the interview that they could stop the interview whenever they wished, they could withdraw from the interview at any time and for service-user participants that I would arrange for extra support from their clinical teams should they find the telling of their stories upsetting. This proved unnecessary and all participants who participated in the interviews completed these without obvious upset. Interviews conducted in this study 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.

All interviews were audio recorded and transcribed by the researcher. Transcriptions were returned¹⁶ to all participants to check for accuracy and

¹⁶ Although some studies adopt this approach to achieve what is called 'respondent validation' or 'member checking' this was not the purpose here. I wished to ensure that participants had possession

with the intent of sharing the material provided with the participant. The intention was to make transparent to participants the material that I would later use for analysis. In two instances participants (one nurse and one service-user) returned my transcript with some minor corrections of spelling. On a number of occasions workers declined the offer of their transcripts as they explained they did not like to read their own spoken word.

The transcription of the spoken word in interview studies is an important stage in preparing data for analysis. It functions as a permanent record of the interview and allows the researcher to return to the data for repeated attempts at understanding and analysis (Cameron, 2001:31). Analysis of transcripts of interviews allows examination of the structure and form of talk which would be otherwise unavailable for investigation. The process of transcription itself was a long and laborious task and on average one hour of recorded material required approximately eight hours of transcription time. This was achieved in small stages of one hour at a time to preserve concentration and my aching back, and continued throughout the period of data collection. The research interviews totalled fifty-five hours of recordings. Using my estimate of eight hours transcription per hour of recording, this took more than four hundred hours to transcribe. It is likely however that my rate of transcription varied over time and possibly quickened as I became more proficient with the technology.

The established tradition in social sciences research is that transcription of interviews allows the researcher to become immersed in the data. Bird (2005) goes further and suggests that transcription itself is an interpretive act and therefore decisions about what gets transcribed and how, form part of the process of what gets analysed.

It is less clear to me that transcribing is an interpretive act, however it seems instead that decisions on what to include and how to notate transcripts are influenced by theory. Repeated listening to the audio recordings while

of the transcript material as a way of sharing ownership and for the practical purposes of ensuring accuracy of the transcribed recordings which sometimes were difficult to hear clearly.

transcribing did induce familiarity with the data although my impression has been that a focus on getting the transcriptions 'right' was my main preoccupation. The style of transcription and the conventions used are to an extent dependent upon the theoretical approach and what analysis the transcripts will eventually be used for. Conventions for transcribing vary across the social sciences literature, so for example the highly annotated conventions seen in conversational and discourse analysis studies are necessary to allow for the micro-analytical focus in these approaches (an example developed by Gail Jefferson is used in Antaki and Widdicombe 1998: vii-ix). Detail of transcription and use of symbols in this study were kept to a minimum and are described at the beginning of this thesis (see page 12).

Essentially what was transcribed was what could be heard and perhaps this is illustrative of Bird's suggestion of transcription as an interpretive act. In each case I transcribed the words and sounds as heard on the tapes as accurately and faithfully as possible. Responses such as *hmm*, and *uhuh* offered by the researcher during the course of a narrative delivered by a respondent were not transcribed although all substantive interjections have been included. The form and content of the narratives were privileged in this respect as this formed the focus of the study. Pauses were noted in brackets in the transcript where these were timed to the nearest complete second. The purpose here was to contribute to an understanding of the pace of delivery of the account and to allow judgements to be made about the significance of pauses in relation to the potentially sensitive elements of the account. I have not chosen to make these judgements in my analysis but include timed pauses to aid transparency and credibility of my attempts to understand utterances organised as stories.

Despite the use of a digital recorder and external microphone some recordings were difficult to accurately hear. In some instances the recorder was picking up peripheral sounds making some speech inaudible. This problem ceased once I dispensed with the external microphone. Where I

have been unable to discern speech in the recordings these have been marked on the transcripts.

I have been concerned with achieving accurate transcriptions of research interviews. Atkinson (1995:12) notes that a

“tension between readability and fidelity is a recurrent issue for ethnographic analysis and there is no pure or perfect mode of representation”.

As I have noted conversational analysis and some forms of discourse analyses used highly annotated conventions for transcription. These research approaches require micro-detail in transcription to facilitate analysis. Atkinson (1995) argues however that in more general studies of talk, care has to be taken to ensure transcription symbols don't make what is said unreadable and ultimately detract from, rather than inform, analysis. This may be particularly the case in studies of social actors own understandings of everyday practices. My approach has been to achieve transcriptions for my intended purpose of examining stories and the work that these are used to accomplish. I have used standard spelling and punctuation where possible so as to make what was said intelligible. I have tried to remain faithful to what was said by participants rather than aiming for the “illusory fidelity of over-detailed and unreadable textual representations” (Atkinson, 1995: 13). As such I have made no attempt to capture the various forms of pronunciation used by participants during research interviews.

I have given pseudonyms to all participant transcripts used in my analysis and omitted names of persons, places and readily identifiable institutions providing health and social care to this population. My aim has been to preserve anonymity and confidentiality of participants and those they refer to as much as possible.

3.5 DATA ANALYSIS

As indicated all audio recordings were transcribed as fully as possible by the researcher and transcripts were read repeatedly, facilitating familiarity with the data. The transcribed research interviews amounted to over 350,000 words in fifty-nine separate documents. The transcriptions were then uploaded to the computer programme N6. This computer-assisted analysis package was used primarily as a data management tool so that documents could be easily stored, retrieved and coded to aid further analysis. Computer programmes however are no substitute for the usual process of interpretation and analysis although they can prove useful in automating aspects of organising the data.

Each transcript was given a unique identifier code and transcripts of service-user, community mental health nurse and social supervisor interviews were grouped together in folders to aid easy identification and comparison between accounts. The identifier code contained information related to the rank order of interview completion, research setting and participant so that it was then possible to identify respective service-user and linked professional transcripts.

Each transcript was coded using what the N6 programme describes as 'free nodes'. This is a form of open coding allowing text to be coded line by line or in larger 'text units' (see Appendix 7). The decision was taken to code the transcripts line by line but to do so in larger text units to preserve the context of utterances and to facilitate fine grained micro-analysis during subsequent coding. This open coding utilised the content of the talk as the focus for coding so that for instance passages of talk that described processes of preparation for discharge were coded under broad descriptive headings such as "leaving hospital". N6 allows for descriptive tags and memos to be added for each code. The use of descriptive tags provided a useful indication of extracts coded under a particular node. Memos were written to chart developing insights and analytical points arrived at during the coding of transcripts. These were particularly useful when analysis had to be suspended due to work commitments and enabled the threads to be picked up again when I returned. Segments of transcript were sometimes given

multiple codes so that for instance an extract could be coded as “leaving hospital” but the content may also be in the form of a structured story. The interest in gathering together more clearly defined narrative utterances to allow exploration of how they were used in the interview talk necessitated a coding scheme that ensured these stories were additionally coded as complete segments.

Subsequent steps of coding into ‘tree nodes’ within N6 followed the process identified by Braun and Clarke (2006) to reduce the data into manageable chunks. The aim was to produce a detailed and exhaustive category system of issues raised in each interview and to link interviews and categories together. This approach can be used to identify, analyse and report patterns in interview data (Braun and Clarke, 2006). Categories were then examined in the light of the research questions and specific areas of analytical interest.

Transcripts were repeatedly read with the intent of locating where the main foci existed relative to the research questions and to inform the developing analysis. A coding frame based upon the main research questions was used to inform further analysis. Codes were attached to instances of talk that displayed identity-relevant orientation, for example claims regarding roles such as occupation or family roles were coded as identity-occupation and identity-family. Codes were attached to extracts of talk that centered on experiences of arrest, incarceration, criminal justice procedures and formal and informal preparation for discharge. An area of analytic interest was related to identity work in talk involving warranted labels of forensic patient and convicted offender and how this was handled when narrating return to community living. This led to further codes being attached to talk that indicated identity work in accounting for entry to, maintenance of and exit from roles within the context of conditional discharge.

As Antaki and associates (2003), have indicated, simply dividing up and collecting instances of talk into categories is not analysis in and of itself. Indeed the division of interview talk into chunks can distort or lead to



impositions on the data which can privilege the researchers' interpretations and obscure the functional qualities of talk. This is not to suggest that thematic analyses are not viable ways of examining data, Braun and Clarke (2006) have ably demonstrated the contrary. Rather than pursuing the coding and categorising of data to arrive at themes I chose to view this process as preparation of the data for further analysis. This provided me with familiarity with a large data set and helped to determine where to concentrate my analysis of the talk of participants. My analysis focused on examining accounts to determine what was being said, what it accomplished and how this was achieved.

The presentation of my analysis has been structured to address elements of participants' talk which appeared to be important in constructing identities in talk. I have chosen to present my analysis in a rough temporal line (much like a classic narrative structure) commencing with entry to the system and progressing towards talk about discharge, and finally talk about living in the community.

My initial intention was to focus my analysis on talk which addressed preparation for discharge and return to community living. However during the course of preparing the data for analysis it became clear that many service-user participants had talked about their entry to the forensic system. No participants were asked about their index offences, episodes of mental illness or indeed admission to the forensic system. As such it appeared to me that as participants were prioritising these events in their accounts their talk could be treated as produced for the purposes at hand and hence analysable as such.

3.6 CONCEPTUALISING 'SENSITIVITY' IN RESEARCH

During data collection for this study I repeatedly encountered periods where no further service-user participants were being proposed by street level staff. This appeared to be for a number of reasons. First, given the design of the

study it followed that I would have an account from a recipient of the care provided by that worker which may or may not be critical of that care. This evaluative narrative in effect constituted a potential intrusive threat to the working practices of professionals who frequently operate alone in people's homes with no outside scrutiny. Second, it required the worker to provide an account of their work that might differ from the service-user account. This was articulated in a number of interviews when street level participants enquired about what the service-user participant had said or would insert the query, "I don't know if he told you this...?" or "so what did he say to you?" during the course of an account.

It is possible however that service-users themselves were reluctant to participate in the research due to the socially-sensitive nature of the enquiry. This concern has been highlighted previously in attempts to study this hard-to-reach group (Banongo et al, 2005). Recounting past experiences of serious offences and mental ill-health may be seen as socially sensitive and implying threats to identity performance. The challenge was in negotiating an approach that allowed potential participants to have confidence in the conduct, purpose and outcome of the research. Navigating this difficult path is partly dependent upon the adequacy with which the sensitivities of the research subjects are managed.

Much of the literature on sensitive topics relates to threats posed to single study groups (Lee, 1993). Studies with more than a single study group however have to contend with different though related threats for each group. The current study in seeking narratives of service-users, professionals and informal carers or relatives illustrates that multiple threats may exist for participants from different groups. Attuning oneself to these threats so that attempts can be made to address these and secure access to the relevant samples is an important research activity.

Sieber and Stanley (1988:49) refer to socially-sensitive research as those studies

“in which there are potential social consequences or implications, either directly for the participants in the research or for the class of individuals represented by the research”.

Sieber (1993) argues that sensitivities associated with any particular research project may be subjective and it is the participants' view of the risk and sensitivity that must be recognised rather than that imagined by the investigator. It is however the case that a researcher may gain clues as to the potential sensitivity of particular topics through previous knowledge of the subject area and through the process of negotiating access to the setting. Problems with gaining access may be the first visible sign of the perceived sensitivity of the subject. Understanding this sensitivity can assist the researcher in negotiating and maintaining access to the research population.

It is also likely that sensitivities will be evident in the research interviews themselves. Research interviews are social interactions in which sensitivity must be handled in the talk of participants. It became clear over the course of this study that social sensitivity was an important consideration in not only gaining and sustaining access to the service-user population but also during data collection. As such I have addressed this at relevant points in the analysis of talk related to conditional discharge.

3.7 CONCLUSION

In this chapter I have outlined my approach to collecting and analysing stories through the use of research interviews with service-users and workers from two forensic mental health settings. In presenting my approach to data collection and analysis I have sought to make clear the research process. This is an important established feature of qualitative research (Murphy et al, 1998; Spence et al, 2003). For example, Murphy et al, (1998) suggest that qualitative research be judged in terms of the use of systematic methods for coding and handling data. Underpinning theory, conduct, design and analysis of data are all considered to be important elements in judging quality and rigour (Mays and Pope, 1996).

My interest has been in the participants own everyday understandings of social situations as told in research interviews. The utterances of participants have been treated as situated accounts produced for the purposes at hand (Wooffitt and Widdicombe, 2006). My analysis of this data has centred on the functional and action-oriented nature of narrative performance in social situations. This approach is informed by an ethnomethodological concern to examine participants own displays of understandings as one way of investigating conditional discharge.

The chapters that follow in this thesis will present analysis of data collected from interviews with service-user participants, community mental health nurses and social supervisors. The emphasis is placed upon the talk of service-user participants and analysis of professional worker accounts will be presented where this contributes to the developing analysis. The data chapters are structured using a loose narrative of entry to the forensic system, discharge on conditions and life outside hospital under aftercare monitoring.

I begin my analysis in Chapter 4 by examining talk about entry to the system to explore what was being accomplished in these stories. I will show how this talk achieved warranted claims of illness as causative explanations for deviant behaviour and how identity work to establish the person as a moral agent suffering from disrupted biographies was positioned alongside claims of illness. I outline here some examples of talk that show awareness of available competing accounts. This is an aspect of the talk of service-users and workers which I develop further in my analysis in Chapter 5.

In Chapter 5 I move on to examine participants' talk about conditional discharge. In this analysis I focus on aspects of time and rhetoric which are used in the talk of participants to orient towards identities as credible narrators of established facts. This demonstration of credibility worked to show recognition and rejection of competing accounts. I show how these competing accounts were evident in the talk of workers providing aftercare services to the person. A feature of talk of service-user participants was the

telling of stories which demonstrated time-oriented positive directionality or in other words the expectation of improvement in their condition and greater liberty as time passed.

My analysis in Chapter 6 examines the content of service-user talk in relation to aftercare monitoring while on conditional discharge in the community. I explore how service-user participants talked about living in the community on conditional discharge and how aftercare arrangements were constructed in accounts. I show that the talk of service-users was concerned with the degree of control over their lives that is sanctioned by the use of Section 41 conditional discharge arrangements. These arrangements are both formal and informal and participants' talk functioned as complaints about the implications of these powers. For some participants the identity-relevant aspects of intensive aftercare and follow-up from health, social care and criminal justice agencies were constructed as significant hazards of aftercare support. Workers talk constructed their readiness to wield the power of recall as benevolent risk management. I will also show how workers engaged in a form of categorisation of service-users. I argue that these accounts can be read as challenges to identity work of service-users and demonstrate a struggle for ascendancy in terms of which account predominates.

Chapter 7 presents my analysis of participants' talk as emergent identity work. I first address the issue of social sensitivity and how this is handled in the talk of people on conditional discharge. I argue that the handling of identity threats by service-users in social situations is a form of active privacy management. The research interview itself is a site of social interaction wherein identity threats must be managed. I will argue that this action-oriented talk functioned to establish alternative identities which I see as being elements of transition. I argue that the talk of conditionally-discharged people worked to establish an emergent identity of 'ordinariness'. This can be read as the deployment of a benign and relatively mundane identity in everyday social interaction for the purposes at hand.

In Chapter 8 I draw together my findings and present an analysis of talk as social action demonstrated in participants' identity displays in research interviews. I propose that much of the talk of conditionally-discharged people implicates liminal identity work. The claim of ordinariness which is a feature of service-user's talk is first and foremost an identity display which seeks to achieve distance in time and space from previous deviant identities. These displays are 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.

Finally in Chapter 9 I use my analysis to indicate the original contribution of this thesis and to outline some implications for research, education and clinical practice in the field of community mental health.

CHAPTER 4: ILLNESS AND OFFENDING: MANAGING COMPETING CLAIMS IN THE STORIES OF THE CONDITIONALLY-DISCHARGED

4.1 INTRODUCTION

In this chapter I commence my analysis of the stories told by service-user and professional worker participants of conditional discharge and community return. The chapter is structured around the talk of service-users related to entry to the forensic mental health system. In subsequent chapters I will examine talk related to other phases of conditional discharge. The decision to report my analysis in this way is partly for presentational purposes. It will also help to show the varied identity work of participants in their talk in relation to the different phases of their passage through the system of care. In this chapter I examine talk about entry to the system to explore what was being accomplished in these stories. I will show how this talk achieved professionally sanctioned claims of illness as causative explanations for deviant behaviour and how identity work to establish the person as a moral agent suffering from disrupted biographies was positioned alongside claims of illness.

Stories offer firsthand accounts of the process of conditional discharge from 'the inside', allowing people to tell in their own words the experiences of transition between where they were before and where they are now. These stories therefore are given explanatory power and allow the researcher to hear what people say about their experiences. They also provide the opportunity to explore how talk is structured in accounting for entry to the forensic mental health system.

While there are multiple possible trajectories for people within forensic mental health services, it appears that transition to community living encompasses two distinct but parallel processes. These are the situational/physical move to community living and the dispositional/identity transition the person must

make. In this chapter I will show how, in talk about entry to the forensic mental health system, stories function to achieve credible accounts of changing personal circumstances, constructed with an awareness of other competing versions that are culturally available. These include accounts that portray the offenders' life in less favourable terms. This in essence is how the person, through means of their interview talk, manages or accomplishes their identity as a person with a history of mental illness and criminal conviction who is now living in the community.

Stories told in research interviews can have rhetorical power aiming to persuade or convince the listener. They can also function to argue, resist or challenge competing accounts and provide alternative ways of describing things (Edwards 1998). Serious criminal offending and mental illness are liable to be labelled deviant¹⁷ and as such have implications for social identity. I will argue that in telling their story participants accessed social and cultural information on what was liable to be deemed deviant, and as such their accounts are oriented toward addressing these competing versions of events.

In this chapter I will present an analysis of interview talk of entry to forensic mental health system using extracts from three interviews with people on conditional discharge. The analysis will show that in telling their stories, conditionally-discharged people accomplish the category of a sick person who may not be deemed fully responsible for his/her behaviour. The analysis will show that the stories produced in research interviews displayed awareness of, competing accounts, and demonstrated acceptance or rejection of these. Acceptance of competing professional accounts was demonstrated in the talk of participants in terms of legitimate absence from roles and softening culpability in relation to criminal offending behaviour. Rejection of competing professional accounts was in part achieved by constructing disrupted life

¹⁷ Conrad and Schneider use the term 'deviance' to mean a process of negative defining of behaviour that is condemned within society. They argue that it is not the behaviour itself but the definition of it that makes something deviant. I use the term here and throughout in a similar fashion, that is I see deviance as being constructed by social groups for the purposes of labelling the social action of others which has been deemed to have broken expected rules or norms. This is in line with sociological labelling theory suggested by Becker (1963); Scheff, (1966, 1984); Erikson (1966) and Lemert (1972).

trajectories to establish negative effects of contact with forensic mental health services. These accounts also demonstrated that awareness of competing accounts extended to notions of medicalisation of behaviours. This rhetorical work appeared to be mobilised in the talk of participants for the purposes at hand, for example in managing claims of illness versus criminal deviance.

Analysis of twenty two service-user interviews for this study illustrates the multiple stages of participant experiences ranging from events prior to their index offence, to commission of the offence, to apprehension and incarceration, to trial in crown court, to detention in forensic mental health facilities, to mental health tribunals and eventual conditional discharge and return to community living. I have illustrated these stages in figure 4:1.

Movement through the system is not in one direction only and the stories that were told did not all follow this simple linear path. Figure 4:1 however presents a reasonable overview of the pathways which many service-user participants had taken, albeit with interruptions, setbacks and sometimes return to previous stages along the way.

In table 4:1, I have summarised brief demographic information of service-user participants to enable judgements to be made about the similarity or difference of this sample to others studied elsewhere. The additional thirty seven interviews, with social workers and community mental health nurses providing support and after-care to the service-user participants, presented a range of supporting and at times competing accounts of events and identity claims.

For the purposes of this chapter I will present an analysis of the stories told in relation to admission to hospital. Participants were asked to tell their stories in relation to discharge from hospital. However in some instances they chose to commence their accounts with reference to the events which led to their admission to hospital. Others referred to these events later in their accounts. The prioritising of what to tell was left open for the participant to decide. My

intention here is to address this priority by examining talk about entry to the forensic mental health system and to explore the identity work it functioned to achieve for conditionally-discharged people now living in the community.

4.2 ADMISSION TO HOSPITAL

The process of admission to a forensic mental health facility is one which is inevitably entwined with initial offending behaviours and the judicial proceedings subsequent to these behaviours. Stories told by service-user participants in interviews for this study however rarely commenced with reference to the offence itself. Indeed no service-user participant was directly asked to talk about their index offence. Some chose to talk about events surrounding their offence while it was omitted in the accounts of others. Both the choice to talk about the index offence and the choice not to talk about it are, I will argue, active choices which may relate to handling identity threats but are also relevant to the structure of the story itself. Put another way, participants' talk may manage the possibility of negative labelling in the social interaction of the research interview by the tactical placing of talk related to offending behaviours.

The initial route to a forensic mental health facility for participants was through the judicial system and participants' stories recount transfers from prison or courts to hospital. These stories tell of a time which for many participants was their first formal encounter with the police, courts and prison systems. The stories necessarily recall emotionally difficult events which were often experienced within the context of mental distress. Handling this potentially sensitive information within a research interview is a functional task of the narrative and I will attempt to show how this was accomplished in the interview talk.

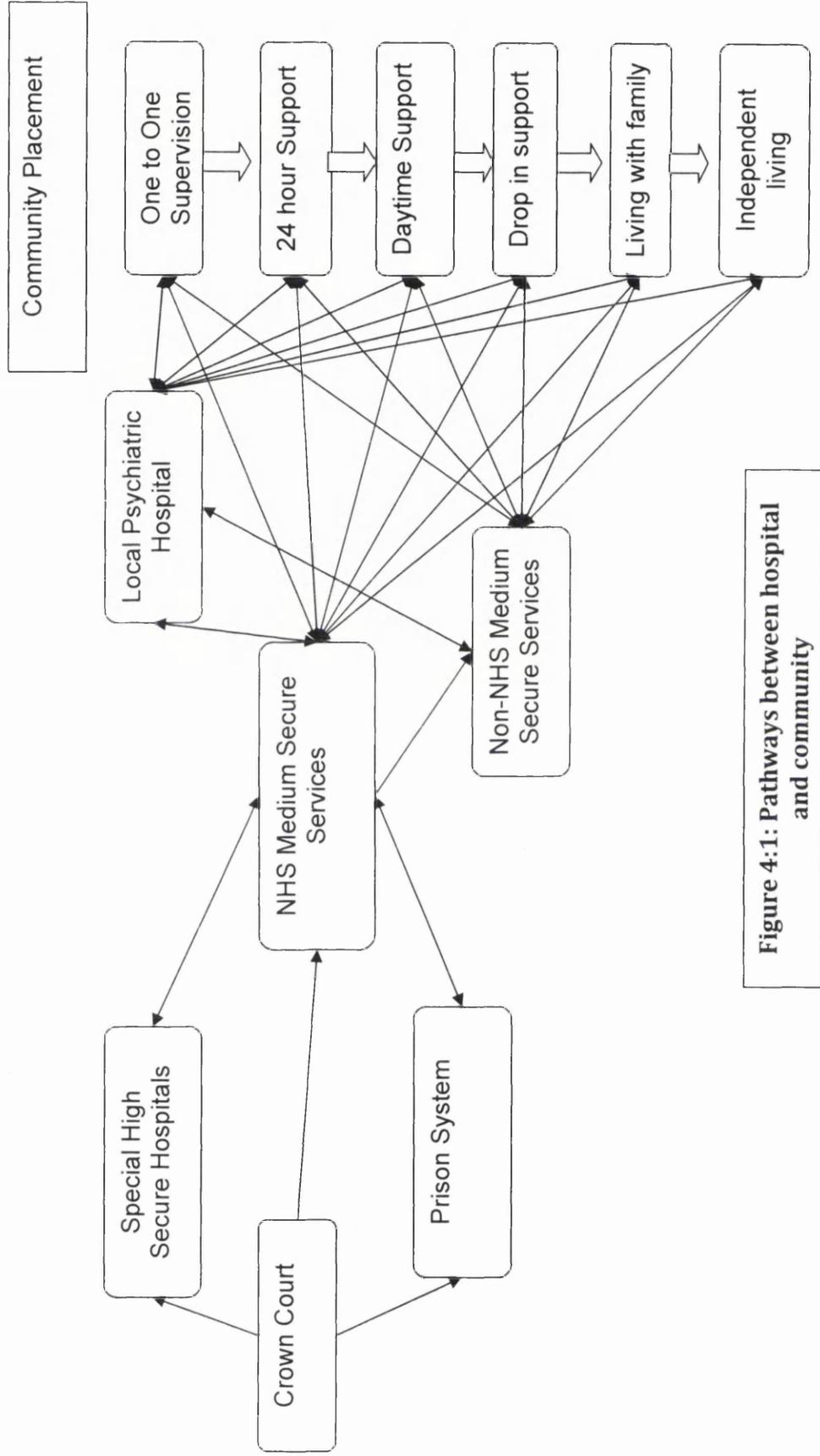


Figure 4.1: Pathways between hospital and community

	age	gender	Time discharged	Contact with family	Contact with professional workers	Current accommodation	Daytime activity	History of recall
SU1: Setting 1	50	M	10 years	Yes	other	independent	other	Yes
SU2: Setting 1	60	M	9 months	Yes	other	independent	retired	No
SU3: Setting 1	32	M	1 year	Yes	other	independent	Part-time employed	No
SU4 'Brendan': Setting 1	67	M	3.5 years	Yes	weekly	independent	retired	No
SU5 'Colum': Setting 1	42	M	9 months	Yes	other	independent	Unemployed	No
SU6 'Fred': Setting 2	77	M	3.8 years	Yes	other	supported	retired	Yes
SU7 'Iestyn': Setting 2	37	M	2 years	No	weekly	supported	Unemployed	No
SU8 'Dave': Setting 2	51	M	3 months	No	weekly	supported	Unemployed	Yes
SU9: Setting 2	30	M	4.5 years	Yes	weekly	independent	Other	No
SU10: Setting 2	42	M	3.5 years	Yes	weekly	independent	Voluntary work	No
SU11: 'Niall': Setting 2	40	M	2 years	No	other	supported	other	No
SU12: Setting 2	35	M	5 years	Yes	other	independent	Full-time employed	No
SU13: Setting 1	-	M	1 year	Yes	other	independent	Unemployed	No
SU14: 'Tim': Setting 2	38	M	3 months	No	weekly	supported	Unemployed	Yes
SU15: Setting 1	27	M	1 month	Yes	weekly	supported	other	Yes
SU16: Setting 1	54	F	5.5 years	Yes	monthly	supported	other	Yes
SU17: 'Maeve': Setting 2	41	F	9 months	Yes	other	supported	other	No
SU18: 'Lloyd' Setting 1	37	M	9 months	No	other	supported	Part-time employed	No
SU19: 'Bill': Setting 2	42	M	6 months	Yes	weekly	supported	other	Yes
SU20 'Bryn': Setting 1	38	M	3 months	Yes	other	independent	other	Yes

Table 4.1: showing demographic information collected from service-user participants

The extracts included here illustrate the multiple, meandering and at times complex routes to hospital admission following the index offence. Section 37/41 of the *Mental Health Act* is used by the Crown Courts in cases where serious offences have been committed and where mental illness was deemed to be verifiably implicated in the commission of the offence. Some participants had long histories of contact with mental health services while others had had minimal or no contact with services prior to their arrest. The decision to involve mental health services was sometimes constructed by both service-users and workers as a tactical move by legal teams representing the person but more often it was serendipitous referral for assessment from staff in police stations, court holding-rooms or prisons.

4.3 “I WAS HARDLY EVER OUT OF HOSPITAL”: THE MORAL CAREER OF THE PATIENT

For some interview respondents the eventual admission to a forensic mental health hospital was a culmination of many years of contact with formal health and social care services. This extract is taken from an interview (lasting approximately one hour) in research setting two with Maeve who had left hospital only months before. Admission to hospital for Maeve occurred in the context of repeated mental distress which had necessitated numerous stays in local psychiatric and general medical hospitals. Maeve had a relatively poor social background in that she had infrequent, unskilled, poorly-paid employment, had spent time in children’s homes as a child, had unstable relationships as an adult and had seen her own children taken into local authority care when she struggled to provide adequate care for them. In this interview extract Maeve describes a time, following a serious suicide attempt, when a period of recovery in a local general hospital had come to an end. The decision to discharge her was presented as directly implicated in the commission of the index offence. Maeve was a woman in her early forties who was at the time of the research interview living in supported accommodation. She was expecting to move to more independent living in a sheltered housing scheme in the near future. It was perhaps not surprising to

find that she saw her recent conditional discharge from hospital as a chance for a new beginning.

The extract presented here followed on from lengthy segments of talk in which Maeve recounted her experiences of leaving hospital and living in her current placement. In this interview extract she returned to events preceding and leading to her being placed on the restriction order and consequent admission to a forensic mental health hospital.

- 110 MC: since you've left hospital, have there been things that have made it easier to be
111 out?
- 112 R: yeah not being locked up all the time [laughs] yeah more freedom and yeah. (2)
113 The staff are brilliant (2) you know it's not like they are just doing their jobs. They're
114 like friends to you. It makes things a lot easier being able to talk to them and they
115 listen and you know and that and that helps a lot. (4) Before I went to [medium secure
116 hospital] there was a lot of issues. I had a lot of therapy, intense therapy (2) which was
117 really hard umm I had that once a week for about three and half years (1) sometimes
118 more umm which I had to go through all my past and everything and (1) sometimes I
119 used to think oh God I can't I can't cope with this. Sometimes I hurt myself after
120 sessions and then it got easier and easier you know. As long as I knew people weren't
121 judging me (1) you know and it's your fault and because I was doing that to myself,
122 it's your fault you know but they didn't. They made me look at things from a different
123 perspective.
- 124 MC: so you were in a different place before [medium secure hospital]?
- 125 R: yeah I was in [name] Unit [local psychiatric hospital] where I'd been going for
126 about 10 years, I was hardly ever out of hospital umm (2) and then umm I jumped off
127 a bridge and umm (2) I was in hospital for a good while. Anyway I was still in plaster
128 and they said to me you're going home now. I was living in a house, I couldn't get up
129 and down the stairs, my bathroom was upstairs so I couldn't have got up and down to
130 go to the toilet umm you know and they just didn't seem to care. I couldn't even go to
131 the shop you know or anything because it was too far away from where I live and I
132 had no one at all and umm they were sending me home. I had no money either. I had
133 no electric and gas it had been cut off because of the time I was in hospital so I went
134 in my bedroom in the hospital and set fire to the bed. (1) I was going to go to prison
135 (2) until I saw umm a consultant from [medium secure hospital] and I talked to her for
136 about 7 hours on two occasions about all my past and everything and she said I think
137 we can offer you a place in [medium secure hospital] (1) and I thought thank God for
138 that. (2) Umm of course they really got to know me then when I went to live there
139 umm there was some really difficult times and things but you know I just got through
140 it all and I'm just so glad I went there. One because I think I would have been dead by
141 now umm or I would have ended up in prison for (1) a long time.

[Maeve Interview: Setting 2: lines 110-141]

This account of admission to a forensic hospital achieved the work of describing the events beyond the interview talk. It did so by establishing the context of life events leading up to entry to the hospital system. The account achieved both the explanatory work of accounting for what happened and made events beyond the talk available to be passed on in the telling of the story. The story was of admission to a forensic mental health hospital following the setting of a fire which resulted in arrest, detention in prison and eventual conviction.

The speaker signalled what was to come in lines 115-116 with the statement “(4) Before I went to [medium secure hospital] there was a lot of issues. I had a lot of therapy, intense therapy (2)”. We are to understand that there had been significant problems in the life of the person leading to events that were about to be retold in the interview. These problems required not just therapy but “intense therapy”. This qualification of therapy as being intense functioned to set up what followed and established the emphasis for the listener. This was followed on line 117 with reference to how therapy was no easy option, it was “really hard”, therapy occurred frequently and over a prolonged period of time. This therapy involved going over past events [line 118] and in this turn the speaker embellished the ‘issues’ mentioned earlier with the phrase “I had to go through all my past and everything”. The distress caused by this therapy was described by the speaker who found it difficult to cope and sometimes hurt herself following sessions [lines 119-120]. This turn functioned to provide an explanatory backcloth to the story that followed. This sequence of talk indicated that the speaker was aware of competing, less positive accounts that might be available for instance, people “judging” her [lines 120-121]. To an extent the story pre-empted these alternative accounts by outlining the speaker’s commitment to addressing her problems by what is framed as prolonged and difficult exposure to therapy.

The story moved on following my prompt to establish the sequence of events, with a clear orientation to a place, the local psychiatric hospital which the speaker had been attending for ten years [lines 125-126]. This was followed

on line 126 with another reference to the seriousness of the speakers' problems before the sequence of events was outlined with the dramatic if hesitant "(2) and then umm I jumped off a bridge and umm (2)" [lines 126-127].

Maeve outlined a problem with the events experienced in that she was "still in plaster" [line 127], when told she was being discharged. The problem signalled by the use of "still" in line 127 was then further elaborated so that it is to be understood that a return home after a long admission would present a number of functional complications for her. These included problems with access to bathroom, toilet and local shops as well as having no money, gas or electricity [lines 128-132]. This list of problems served to highlight the difficult position of the speaker. Maeve's talk constructed events as placing her in an impossible position, she could not be expected to return home "in plaster" with no money, gas or electricity. "Still in plaster" can be seen as accessing commonly available knowledge of reduced mobility and consequent problems with access to toilet facilities and local services. Notions of reduced mobility may be more readily understandable than those of mental distress and as such function to convince the hearer. It was a very persuasive account in this regard and structurally provided the space within the narrative for revealing the detail of the index offence. This was framed as a further sequence of events in lines 133-134, "so I went in my bedroom in the hospital and set fire to the bed."

The talk produced in this story had the form of an account which Scott and Lyman (1968: 46) define as a

"linguistic device employed whenever an action is subjected to valiative inquiry"¹⁸.

¹⁸ Orbuch (1997) has widened this definition to include other forms of stories or narratives which are seen to provide insights into embedded normative explanations. I have chosen for clarity in this instance not to confound a particular type of story in the form of an account with wider notions of narrative. I have focused here on Scott and Lyman's more specific notion of situated standardised forms of talk that are routinely expected when behaviour falls outside expectations.

That is accounts are forms of talk provided by a social actor to explain unexpected or untoward behaviour that is not culturally coherent. Accounts are called for when an activity falls outside of expectations. Maeve accounted for her actions of fire-setting in response to the intention to discharge her home. Fire-setting in this circumstance was untoward and outside of expectations. Statements of untoward or deviant behaviour may lead to fractures in relations and jeopardise interaction. Accounts are one way of dealing with this problem. Maeve addressed this within her story by providing a particular type of account which Scott and Lyman refer to as an excuse. Excuses are socially approved vocabularies for mitigating responsibility. They are a form of account in which social actors accept an act as bad or wrong but avoid acceptance of full responsibility for the act. Maeve in her account achieved this through placing responsibility firmly with the staff who didn't seem to care. The account functioned to position the outcome of the index offence as being the logical sequel to the constructed enduring distress earlier elaborated, but more particularly to mitigate responsibility for negative or deviant behaviour.

The resolution to this story was presented in the description of the meetings with the psychiatrist that resulted in detention in a medium secure forensic mental health hospital (135-137). The talk in these lines, "I talked to her for about 7 hours on two occasions", appeared to be structured to manage and reject competing accounts of illness designation which might be otherwise available. The speaker having earlier established the chronicity of the mental distress was then able to present the meeting with the psychiatrist as an event which required sustained involvement. The phrase '7 hours on two occasions' works to establish that this was no minor undertaking. The mental distress was to be seen as very real and required significant amounts of commitment and endurance to address.

Maeve indicated that committing to treatment in a forensic mental health hospital while still a "difficult" [line 139] option, was a more attractive for her than prison. Hospital treatment may be otherwise understood as a soft option

which can be secured by feigning mental illness (Rogers et al, 1998) and the function of the talk here was to deal with this erroneous conclusion. The option of treatment in a forensic mental health hospital was presented as the harder choice, as it required commitment to “difficult” treatment and unlike prison there was no confirmed or guaranteed release date. By her own perseverance she “got through it” [lines 139-140] and the story concludes on a redemptive note, “One because I think I would have been dead by now or I would have ended up in prison for (1) a long time.”

Occasioned by the context of the interview Maeve’s account addressed both the turmoil of mental distress, the offending behaviour she positioned as resulting from this distress, its consequences and finally an evaluative view of events. Competing accounts that illness might be feigned to derive benefit in the form of hospital rather than prison detention were thus managed and rejected in her talk.

Maeve’s story re-told events that were constructed as difficult times in which she had limited social supports to rely upon. The relevance of social supports and positive reciprocal relationships are key elements of the notion of social capital (Sartorius, 2003). Earlier in the interview Maeve tried to establish a linkage between the absence of normal social relationships and the index offence, “(4) Yeah I’m not the sort of person who can live on my own (1) because well not, not for a long time because I’m my own worst enemy (1)” [lines 36-37]. Maeve followed this by indicating that her mental distress worsens in the absence of regular contact with others and that her ability to cope with the stresses and strains of life were limited. The extent of the problems that she had experienced and the complexity of her social situation prior to admission for the index offence were continually mobilised as explanatory devices in her talk. This included her experiences of abusive relationships, difficulties in providing care for her children and ultimately the loss of her children to a social services system that she constructed as being unwilling to help her cope.

This narrative accomplished at least two separate types of work. The talk addressed the person's experience of admission and set it within the social and health contexts of longer-term personal problems and mental distress. Persistent and enduring mental ill-health can reduce opportunities for full social acceptance (Thorncroft 2006). Maeve constructed her attempts to address her problems as ultimately fruitless. Maeve assembled in her talk the combination of limited social attachments and poor coping resources as predicaments in returning to a home that was ill-suited to her needs. In doing so, Maeve used the chronicity of her mental distress and her social circumstances in her talk to indicate few options in terms of organising resources to help her to adequately manage her situation. Bury (1982) has suggested that mobilising of resources is an expected response to chronic illness but in some cases, such as with enduring mental ill-health, people have few resources to mobilise. This resonates with an established focus on stress vulnerability in schizophrenia, which hypothesises that once levels of stress surpass the person's ability to cope, a relapse of their condition is a likely outcome (Zubin and Spring, 1977). A common preoccupation in mental health services has been the delivery of interventions aimed at educating people with mental illness about the effects of excessive stress and taking steps to avoid this (Birchwood et al, 1989; Corrigan et al, 2001). Maeve's talk was oriented toward commonly understood notions of mental illness by referencing the variability in personal resources which were constructed as limiting her options and leading to her index offence.

Many of the opening turns of Maeve's talk were used to establish that problems existed and these were constructed as being the result of an unnamed condition which required significant ongoing support. Once the events immediately preceding the index offence and the offence behaviour itself were established as the antecedents to a crisis in her talk, an opening was created for Maeve to construct her efforts to address her problems. Thus her talk depicted the interview with the psychiatrist as a turning point in enabling her to address her problems more directly. Maeve referred to admission to the forensic hospital as "when I went to live there" [line 161].

Events such as her arrest, conviction and detention did not appear in Maeve's talk during this research interview but rather events were constructed as the opportunity to secure the help she argued she desperately needed. In effect Maeve (and other service-user participants as we shall later see) used her story to address concerns about deviance, by indicating her moral standing in the form of her efforts to address her circumstances and her condition, through engaging in difficult and at times distressing mental health treatment.

Maeve's account and that of the social supervisor framed her circumstances as socially disadvantaged, mentally distressed with limited resources and positioned the outcome of this nexus of events as being almost inevitable. The social supervisor had known Maeve for approximately one year and my interview with him took place in his office in setting two. The social supervisor in the extract below indicated that services were largely unable or unwilling to facilitate the elements of social capital development necessary to help Maeve build her recovery. The social supervisor constructed Maeve's response to this predicament as being in part a result of negative experiences of seeking help from services which were unable to address her range of needs. In this extract he alluded to the extent of the problems that Maeve had been experiencing and which she referred to as 'issues'.

263 MC: she is interesting because she's in that position where she has lost contact with
264 her children and she is only the second woman I've seen, so it is a very different
265 perspective.
266 R: And, and it would be interesting to look again the differences with a 41 because
267 she sees it absolutely as a positive benefit and a positive benefit in the guarantee it
268 gives her (1) the guaranteeing and the issue of course if you look at her offending, the
269 issue about the offending was, she goes into hospital we're all, oh she's back again,
270 we can't ever lift this woman out of depression, she just harms she self harms she
271 wants more than we can give, you know what I mean. But what the 41 does is you
272 have to give that service, yeah you are ill you do need it and what has been brilliant
273 for her, she wants it, it validates her....

[ASW301105 interview: Setting 2: lines 263-273]

Scott and Lyman (1968) note that accounts offered in mitigation may be honoured or not honoured by other social actors. This depends on

background expectancies which refer to taken-for-granted ideas shared by social actors and which might be understood as information that everyone is said to know. Accounts offered by one person and honoured by other social actors may more clearly be seen within interactions between those parties although in these extracts we see that Maeve's account is honoured by her social supervisor. They share similar background expectancies concerning the effects of social and mental health problems and the outcomes associated with them. The social supervisor constructed mental health and social services which were unable to cope with Maeve's condition. The conditional discharge order, the Section 41, was framed as an effective means to provide care which was an important missing element in her previous encounters with services.

For both Maeve and her social worker the index offence itself was cast as a minor event causing in the words of the social worker "minimal damage umm but causing everybody a great deal of alarm" [line 12]. They both assessed the consequence of the conviction and restriction order as being positive and beneficial, allowing long-standing problems to be resolved within the safety of a system that in effect was then compelled to provide the care that was long sought.

Maeve's talk placed the meetings with the psychiatrist as pivotal in her story. These meetings offered an alternative to the prison sentence she would otherwise have faced. It also functioned within the story to establish and externally verify her moral right to patient status. Parsons (1951) proposed that the sick role is a temporarily sanctioned form of deviant behaviour. To claim the status of the sick role the person is expected to seek help from a medical practitioner and adhere to the treatment offered in an attempt to get well. In return the medical practitioner will sanction the absence of the person from other social roles such as employment or family duties and effectively absolve the person of responsibility in varied circumstances. This theory offers a functionalist and structural perspective on the doctor-patient relationship. Maeve's account relies on these cultural understandings to

support her claims to the sickness label (Parsons 1951). However the classic concept of the 'sick role' is somewhat tempered by the contested nature of modern psychiatric care and assumptions that medicine can provide the treatment necessary for the patient to follow (Breggin, 1993; Double, 2002; Crossley, 2006). While the person is expected to seek and follow treatment advice there are no guarantees that in doing so they will actually get better. Goffman (1969: 386) has also identified notable differences in the application of notions of the sick role between those with physical ill-health and those with mental symptoms. One reason for this he suggested was because the symptoms of mental illness breach the very substance of social obligation¹⁹. Parsons' theory may be more applicable to acute conditions than to chronic ones such as enduring mental illness. However in seeking medical warrants for sickness behaviours and the temporary exemptions from social roles that this may involve, people on conditional discharge may be demonstrating recurrent interactive activities of talk and accounting which have the social function of establishing moral rights to patient status. In other words, talk in interaction accomplishes the business-in-hand of accounting for past action by foregrounding illness explanations.

Maeve outlined her sustained efforts in 'intense therapy' over many years and this was provided as a contextual explanatory device for the resulting index offence. She indicates that, despite her commitment to addressing her problems, she was ultimately let down by those providing care following the event that we might construe as a suicide attempt. Perhaps notably Maeve did not claim her behaviour of jumping off the bridge as a suicide attempt and this may be because to do so at that point in her story would have made it difficult to achieve the functions of this particular account. I shall try to outline what I mean by this. This account required that there was a good/moral protagonist, the person speaking, and an unnamed faceless other, who despite the best efforts of the speaker had contributed to events spiralling out

¹⁹ Goffman (1969: 369) illustrated with characteristic vigour the extent to which those with manic type illnesses may not seek medical help but actively deny their need for such help and breach accepted social conventions through 'over-reaching'. He characterised as "havoc" the outcome of determinations of deviance of mental illness in which actors such as family members were not free to leave the social system which had been disrupted.

of control. This was signalled in the interview talk on line 130 with the phrase “they just didn’t seem to care”. That is, by insisting on discharge to what the speaker implies as unsuitable living arrangements for someone with reduced mobility, “they” were constructed as contributing to later events. The allusion to what might be seen as bad staff who don’t care can be seen in this extract of talk to be all the more so when contrasted with the good staff in the speakers current accommodation, who were identified at the outset of this extract as being like ‘friends’ [line 114]. For Maeve’s account to be accepted within the context of the interview (and as I have suggested also more broadly) the omission of detail related to the unexpected behaviour of jumping off the bridge was necessary.

Accounting for admission to hospital leads the person to draw on culturally available information about mental illness. This is to establish the basis for claims that they had little control over events and behaviours, which are constructed as consequent to the mental condition. When recounting admission to hospital, the offence-related behaviours which preceded admission are implicated and must be accounted for. To achieve this, a moral explanation is proffered which implicates the speaker as a victim of both the circumstance of illness and of a system unable or unwilling to provide the care required. Maeve’s account shifts between constructing herself as an active agent in seeking treatment to a passive actor caught up in events over which she has little control. Her responses (in the form of jumping from a bridge or setting a fire) to these events can perhaps be seen as attempts at reclaiming agency. In claiming agency however there is implied moral culpability and this has to be handled carefully in the account. Maeve’s account works to accomplish this difficult balancing act.

Maeve’s story, as told in the research interview, constructs a positive and beneficial outcome of her contact with forensic mental health services. The stories of many service-user participants in this study re-tell both positive and negative experiences of their illness and offending experiences. In the next

section I will examine a common feature of stories of illness which are concerned with disruption to expected personal trajectories or biographies.

4.4 “I’VE COME DOWN IN THE WAY I USED TO LIVE”: ILLNESS AND DETENTION AS BIOGRAPHICAL DISRUPTIONS

The stories of participants sometimes described a sequence of events in which mental distress was present and unresolved prior to the behaviours which resulted in the index offence being committed. The emergence of symptoms of mental illness and their effects upon the person effectively interrupted the person’s expectations for a particular planned, or imagined, future life. The example presented in this section was taken from an interview (lasting one hour and twenty four minutes) in research setting one with Colum who had left hospital within the last year. Colum was in his early forties and previously worked as a warehouse man. His arrest and detention for the sexual and violent assault of his partner led to a worsening of his mental condition to the extent that he was eventually transferred from prison to a medium-security mental health facility for treatment. Colum’s arrest and prolonged detention resulted in his loss of employment, the irretrievable breakdown of his relationship and the repossession of his home when he was unable to maintain his mortgage repayments. The extract below was taken from the beginning of the interview following a number of turns in which I asked for background details such as how regularly he was visited by his CPN or social worker. The interview took place in Colum’s flat which he had recently moved to from a supported housing placement where he had spent time immediately following his discharge from hospital.

60 MC: So how did you get here to this position in your life?

61 R: Eh, how did um, no exactly sure what you mean

62 MC: What events brought you [to

63 R:[rsu]?)

64 MC: well yeah

65 R: Well I was in a relationship and the relationship broke down, umm here was a lot
66 of problems and I ended up having a breakdown and I was ill in, I went to [name]
67 prison and I started hearing voices and um things like that, I just thought that

68 everyone was against me and that's when I ended up into the [rsu]. They took me
69 from there.
70 MC: You went from [prison] to the [rsu]
71 R: From prison yeah, I found it really hard in prison (3) there was a lot of things going
72 on there you know and I just felt really strange there like.
73 MC: So you started hearing voices when you were in there
74 R: Yeah and I just thought that everyone was against me in there. (9) I did try to seek
75 help before the offen- you know before I went in there and I went to [local psychiatric
76 hospital] and that and I wasn't getting a very good response and I left there and came
77 back home and that's when it all it started going wrong then that week.
78 MC: So you where an inpatient for a while there
79 R: I just signed myself in there I did but things weren't working out in there and I
80 didn't like the way they were treating me and I just left.

[Colum interview: setting one: lines 60-80]

Colum's admission to hospital resulted from his worsening mental health while in prison on remand. He described a not unusual scenario in which arrest and imprisonment leads to deterioration in mental health. It has been estimated that as many as 90% of prisoners in England and Wales have a diagnosable mental illness, substance abuse problem or both (Office of National Statistics, 1998). Where they exist, prison in-reach programmes (Emslie et al, 2005) offer mental health assessment, provide treatment and if necessary arrange transfer to NHS facilities for people in mental distress. In his case Colum was on remand in a prison where an in-reach programme existed and detection of his symptoms prompted his transfer to the forensic mental health facility.

Colum's account has some similarities with Maeve's account in that he too talks of seeking professional help prior to his index offence but had found this to be unhelpful, "I wasn't getting a very good response" [line 76] and not a positive experience, "I didn't like the way they were treating me" [line 80]. While Colum did not allude to persisting with his attempts at seeking help, his talk indicated that he took the initiative in seeking assistance for his mental distress, "I just signed myself in there" [line 79]. Colum stated at the outset that he was to be seen as being "ill" [line 66] which was the result of his relationship breaking down [line 65] and the problems associated with this. Illness was constructed as something that could happen to anyone and perhaps was not that unusual. Colum's talk however then moved to "I was ill in, I went to [name] prison and I started hearing voices and um things like

that,” [lines 66-67]. It is clearly not usual to go to prison following a relationship breakdown. At this point in the story the discrepancy between relationship breakdown and subsequent imprisonment was not accounted for and it was not until much later in the interview that we learn more. The omission of this highly consequential element in the sequence of events told in this story was necessary to allow the story to function as an, ‘it-could-happen-to-anyone’ narrative. Because no untoward event was described no account was called for. Including a declaration of the nature of the offence in the story may also leave one open to claims of particular types of social deviance which at this point in the interview could risk termination of the interaction or jeopardise attempts at garnering sympathy from the listener. This may be particularly so for criminal offenses which are likely to give rise to strong societal reactions and therefore open the way for negative labels which are hard to shake off.

Colum’s account functioned to achieve the moral standing of the patient who was to be seen as ill and who had taken reasonable steps to seek care and treatment. This care and treatment was constructed as insufficient or qualitatively poor and resulted in a worsening of his condition when Colum returned home, “that’s when it all it started going wrong” [line 77]. The implication was clearly laid that if this care had been better and more responsive, events would have transpired differently.

For Colum his offence, arrest and detention in prison marked a significant and fundamental shift in his perception of his life trajectory. He was in a steady relationship, had a job and was paying a mortgage on his own property. These were each markers of his independence and his imagined future prospects. The utterance “when it all started to go wrong” was the first instance where the speaker signalled a disruption of life trajectory and this recurred throughout the interview for example when Colum noted that “I’ve come down in the way I used to live” [line 411]. Colum’s talk implied a personal value-based directional view of his life trajectory that had been turned on its head. He outlined that now he lived in a flat which he saw as

less favourable than the house he once owned and that he could no longer get a mortgage as his previous property was repossessed. Colum appeared to be indicating what Michael Bury has referred to as a biographical disruption as his “expectations and plans ... for the future have to be re-examined” (Bury 1982:169).

Bury suggests that when faced with a disrupted biography of chronic illness individuals have to contend with the problem of future uncertainty. The illness, its symptoms and the limitations it places on their functioning tests the tolerances of others. Medical labelling of the condition and its seriousness will in effect warrant the behaviour of the individual, so that in some settings it will not be deemed deviant, if only temporarily, and may even be tolerated. Bury (1982) argues that in circumstances of chronic illness the individual is prompted to re-evaluate their self-hood suggesting that identity threats are implicit in enduring ill-health.

In physical ill-health the illness and the self are conceived as separate from each other and the medical labelling of illness is an important element in allowing the individual to maintain the distance between self and illness, although as Bury has suggested this line may be blurred in chronic conditions. However in mental illness as Estroff (1989) has noted, the illness and the self are entwined and people struggle to establish this distance.

Mead's (1934) proposition that the self is created through experience developed in interaction with others, the self and the world at large opens the way for the self to experience both negative and positive interaction (Sells et al, 2004). Estroff's (1989) view is that negative social reaction to mental illness has significant effects upon those experiencing these reactions to the extent that they will make efforts to manage, accommodate and reformulate interactions in their identity work. Colum's reference to a disrupted biography in his talk can be seen as reflecting an ongoing process in which he was re-evaluating his selfhood and managing the identity threat implicated in the deviance label.

It seems that the disruption due to illness was prioritised in the account to assert the moral position of the speaker. Put another way, Colum had suffered an interruption to his expected life trajectory as a result of his illness and detention. The prioritising of this biographical disruption in his story was perhaps then a counter-weight to the later revelation of offending behaviour which although disputed was nevertheless of such a nature as to warrant a particularly 'sticky' deviant label.

Colum's account worked to show his transition towards community living as being a process in which he had to re-evaluate his life within the context of a persistent and chronic mental condition. This condition was perceived as a significant biographical disruption which had altered his expected life trajectory. However Colum's criminal offending behaviour had also to be accounted for. His re-evaluation must also accommodate the offence he had committed, which had led to increased external scrutiny of his life by professional agencies and was constructed as limiting his chances of successful social integration. The telling of the story of his admission omitted this detail and perhaps suggested the socially sensitive nature of this information. The offence for which he was convicted was a serious one and perhaps it was significant to the work of this story that he disputed that part of his conviction which would be deemed most deviant. His assertion of the illness label, the priority he gave it above other available accounts and the omission of the critical detail regarding his offence, worked together in this extract to provide persuasive explanatory devices in his talk that were employed to soften the impact of what he later revealed as serious violent assault and sexual offending. The relabeling of his behaviour had presented the threat of locking together his perception of selfhood with the offending behaviour and the illness label. Colum's account functioned to resist these views. However the medical label had also provided him with a ready explanatory device to employ in his talk when called to account for events.

It has been suggested that the labelling of behaviours as either illness or criminality implicates a form of social control (Parsons, 1951; Aubert and

Messinger, 1958, Erikson, 1962, Cohen, 1985; Conrad and Schneider, 1992). Hughes (1980) has noted that there are certain settings in modern societies where such a determination and negotiation of deviant categories regularly occurs. There are certain organisational locales where decisions are recurrently made about available labels and which of these are deemed applicable for different types of behaviour. Many of these sites are located within the forensic mental health system, which functions as part of the criminal justice system to determine which labels are warranted in circumstances where mental illness may be implicated in criminal offending behaviours²⁰.

The recourse to medicalisation of behaviours which attract the full weight of detection, detention and punishment meted out by the judicial system is one which may be a double-edged sword for those caught up in these forms of social control. Some participants intimated however that the opportunity to exploit the potential of this route to treatment rather than punishment, was part of their legal defence strategy. This was constructed as being at the behest of legal teams and for the most part participants indicate little direct involvement in this strategy themselves.

4.5 “THAT’S LIKE WINNING THE LOTTERY”: FROM BADNESS TO SICKNESS

Some service-user participants in this study found their way into forensic mental health services for the first time through a criminal justice route. In some instances this was their first formal contact with services offering treatment for mental distress. The following example is taken from an interview (lasting approximately 2 hours) in research setting one with Brendan who had returned to community living 3 years earlier. Brendan’s first contact with mental health services followed his arrest by the police and the formal criminal charge. The decision to involve mental health services appears to

²⁰ Forensic psychiatric systems actively participate in the selection and application of labels within the criminal justice system so that while decisions about the criminal nature of events remain the remit of legal professionals, forensic mental health workers might also provide a concurrent label of mental illness which offers alternative forms of control.

have been in part prompted by the need to formulate a legal defence. When I met him, Brendan was a retired man living independently in a council housing estate in what was a socially poor and neglected area. He had been described to me by his care team as a 'lovable rogue', which I later came to understand meant he had a long history of contact with the police in which he had largely evaded detection and arrest. His account differed from many of the others in this study in that he chooses to open his story with a statement of his index offence. The story he tells also indicates some disagreement between medical and judicial professions in determining both his plea and his eventual place of detention.

21 MC: Well I suppose what I really want is for you to tell me your story really
22 R: You want me to narrate?
23 MC: Hhmm
24 R: Aye, um (3) I can start off in '95 I was (1) I committed my index offence and uh, I
25 killed 2 people, you were aware of that if you know what I mean, you know that. I
26 killed 2 people and seriously injured another and um (2) to cut half a long story short
27 or whatever it was I was um, convicted of manslaughter (2) by 2 and attempted
28 murder on diminished responsibility on about the 2nd of September 96. (2) They
29 wouldn't as far as I was concerned they would not take me, the Home Office, Crown
30 Prosecution Service CPS and that would not um (1) after three hours with you know
31 what I mean with going back and forth with the judge and with the barristers, um after
32 about 3 hours they came down and said they were willing to accept diminished
33 responsibility but I had to go to [high security hospital] but I always knew because
34 you go where you are sent, you know what I mean? They said that I was too dangerous,
35 I don't know you know with the world you know yourself, they wanted me in [high
36 security hospital] and on about the 21st I was sent up to there. Not, 'cause I had been
37 assessed twice as not suitable (2) for [high security hospital], once from the Home
38 Office and once from the clinic and the Home Office sent this [Dr's name] I think his
39 name was and anyhow they found a bed for me and he came down and changed all his
40 views which I've got no control of anyhow. I'm not sore or nothing about it, God only
41 knows you know what I mean after the index offence, you know I'm, I mean that's
42 like winning the lottery innit you know where I am but then (2) I went to [high secure
43 hospital] and local consultant] I think you've spoken to you know [local consultant]
44 and um [CPN] wanted me there [referring to rsu] so you know, of course he was my
45 private consultant an all, I had him on my own, but I had 2 psychiatrists saying to me
46 there at [rsu] and one thing and another and going down this road if you know what I
47 mean and one of them who's name was [name] said no you've got to go up there and
48 the police said blah, blah, blah you know where I'm coming from? (1) So I goes up to
49 [high security hospital] and I honestly thought well they'll throw the key away you
50 know I mean lets be fair like I know its diminished responsibility and I know I'm
51 fully aware that I was ill at the time if you know what I mean and everybody else was
52 bar the prosecution barrister if you know what I mean, that um psychiatrist and that.
53 But I went up there and I won a tribunal up there in I was up there in I went up there
54 in September '96 (1) and I won at my first tribunal to come back to [rsu] and that was

55 in '97 that was. That was in '97, '98 (2) I came back here and I'd been there 'til
56 millennium year and October 23rd (2) I was released on October 23rd so (2) prior to
57 that um (2) I was released from here then I had a couple of relapses, you know. So
58 I've had 2 yellow cards in effect, one for about a week and one for about 3 months
[Brendan interview: setting one: lines 21-58]

Brendan's account identified him as a mentally disordered offender subject to the jurisdiction and determination of multiple professional bodies. He indicated that the judicial system viewed his offence and mental ill-health from the perspective that he was culpable and therefore paving the way for punitive sentencing. However the psychiatrists took the different view that Brendan was mentally ill at the time of his offence and therefore in need of treatment. Brendan's social worker in an interview conducted in his office, outlined in some detail the lengths he had gone to in establishing an understanding of Brendan's social background. This included visiting the community where the offence had taken place, speaking with people in the neighbourhood and visiting public houses where Brendan socialised. Ultimately this information contributed to a psychiatric formulation of someone with an undiagnosed mental illness who was in need of treatment from the mental health system rather than punishment by the judicial system. As Brendan's account outlined, this formulation was then presented by his defence via the consultant psychiatrist as mitigating evidence to the Crown Court and was instrumental in the decision to accept a diminished responsibility plea.

The 'tariff' applied by the Crown Court when accepting such a plea may vary, with options available to the court ranging from reduced prison sentences to detention under the *Mental Health Act*. Where the index offence is of a serious nature and where evidence of a mental illness is accepted, the usual outcome is for the person to be detained on Section 37/41 in a forensic mental health facility.

Brendan's story offered his perspective 'from the inside', of the process of decisions which culminated in his conviction and his placement on Section 37/41 of the *Mental Health Act 1983*. He offers the view that he was seen as "too dangerous", a view which he apparently distanced himself from in that it

was preceded with the phrase “they said” [line 34]. Brendan was indicating some dispute with this construction which at first appeared at odds with his earlier admission of having “killed two people and seriously injured another” [line 26]. However it becomes apparent that the construction of dangerousness is relevant within the context of his plea of diminished responsibility and the contested view of where he was to be initially detained.

This was offered in lines 35-36, “they wanted me in [high security hospital]”, the implication being that a lower level of security would not have been an acceptable outcome for the prosecution. In other words the construction of dangerousness functions as a contextualisation cue to highlight what the speaker indicates is the disputed nature of the decision to place him in a high security hospital. Brendan confirmed his take on this dispute in line 37 with his statement that he had been previously assessed as “not suitable” for high security care. It appears that the decision on where he should receive treatment was part of the bargaining process between prosecuting and defence counsels. Brendan’s talk about this dispute functioned as a complaint that his “dangerousness” was assessed differently by the same psychiatrist on separate occasions. Despite any implicated advantages that hospital may have held over a prison sentence these are balanced in his account against an apparent lack of transparency with which the decision to detain him in high security hospital care was reached.

Brendan’s account can be read as accessing normative culturally embedded understandings in that he acknowledged the seriousness of his offences as ones which should attract an appropriately matching punishment. He constructs his moral account by indicating (perhaps emphasising the dramatic) that his offence deserved a severe punitive sanction. This is dramatised on line 49 with the statement “and I honestly thought well they’ll throw the key away you know”. The decision by the prosecution to accept diminished responsibility as a plea and hence invoke the use of the *Mental Health Act* was assembled as a stroke of good fortune. The way was paved for this claim with reference to his accepting the seriousness of his offence

behaviour [lines 40 and 41], "God only knows you know what I mean after the index offence". The talk signalled here that the speaker was aware that a serious and significant penalty was warranted and that anything less was a bonus. This was then immediately followed with the phrase "I mean that's like winning the lottery innit" [lines 41-42].

Brendan's account however suggested that he was keenly aware of the contested nature of this decision. He detailed the shifting positions of the opinions provided by two psychiatrists. They had initially agreed the suitability of a medium secure placement only for one opinion to change in the light of plea negotiations between prosecuting and defending counsels. Brendan constructed this as being the result of pressure being brought to bear on the psychiatrist from the criminal justice system. In doing so he framed psychiatric opinion and much of the judicial process as fallible and played out according to parameters which he recognised and was subject to. In accomplishing this claim he left open the question of his own designation of someone with a mental illness and this he swiftly moves onto in the next part of this extract.

Brendan placed the emphasis in his story differently to both Maeve and Colum in that he devoted little space to description of the mental illness that brought him to the attention of forensic mental health services. He more directly claims being ill as a taken-for-granted shared understanding in lines 50-51, "I'm fully aware I was ill at the time". Brendan did not make the same types of claims as other participants in relation to recounting the symptoms he had experienced. One explanation for this may be that he wished to keep these private and was managing the possible social threats that may arise from disclosure of mental illness. However within the context of being interviewed for a study where by implication his status as being mentally ill was not directly questioned then this explanation may not furnish a complete answer.

Brendan's construction of the fallibility of psychiatric opinion alluded to the uncertainty of decisions related to appropriate placement but also hinted at

more widespread uncertainty of conclusions about mental illness. In constructing his account Brendan showed awareness of and directly cited competing accounts which dispute the claims of mental illness. To counter these Brendan used official warrants provided by psychiatrists and his barrister to support his claim. This claim was supported by “everybody else bar the prosecution barrister” [lines 51-52] so it was not to be taken lightly or misconstrued as a neat piece of plea-bargaining. The story was structured with this awareness of possible competing accounts and functioned to convince the listener of the validity of the claims being made. The account addressed the uncertainties of decisions as a means to directly deal with them rather than avoid them.

In effect the story did the work of managing the credibility of the speaker and was therefore identity-relevant. By this I mean that Brendan’s talk indicated that the illness label was one which he privileged over the criminal label. Both labels are identity relevant, they impute certain qualities associated with illness or criminality. Both are potentially available. The illness label worked to warrant the legal and social claims of diminished responsibility. His offending behaviour was to be seen as ultimately outside of his control and for which he could not be held fully accountable. Rebutting the counter claims that he was not ill becomes an important focus of the work to be done in Brendan’s account because the identity threats implied may be viewed as greater than those implied by the illness label.

There has been some attention paid in the literature to notions of medicalisation of particular social behaviours. Medicalisation refers to

“a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illnesses or disorders”

(Conrad, 1992: 209).

Conrad asserts that medicalisation refers to the process that occurs when human problems enter the jurisdiction of the medical profession (1992:210). Medicalisation does not however always directly involve the medical

profession itself but can at an institutional level be enacted by organisations that legitimate medical definitions and responses to a problem. In many cases, though not all, these nonmedical problems are those behaviours liable to be labelled deviant and hence subject to social sanction (Conrad and Schneider, 1980/1992). The medical profession in such circumstances according to Conrad (1992) may be seen as gatekeepers for benefits sanctioned by these organisations.

Criminal offending, such as setting fires which risk the lives of vulnerable people, assault, rape, taking another life, and mental ill-health are usually deemed deviant. For mentally disordered offenders therefore the behaviours which they have demonstrated in the form of criminal offending and mental illness remain subject to sanction. This sanction in the case of serious offences is a criminal conviction with incarceration. In the case of mental illness the sanction is varied and can include voluntary or involuntary treatment in the community or in a mental health facility. The authorisation for enacting this sanction in circumstances where serious offences and mental illness is determined is thus ceded to the forensic mental health system and punishment reconstituted as treatment. This system provides not only incarcerative care in the form of detention for treatment but also transcarcerative care. Transcarcerative care involves the use of multiple agencies engaged in provision of services which offer the opportunity to monitor the health and social behaviour of an individual (Lowman et al, 1987b). This transcarcerative strategy then enables the substitution of a career as a criminal (determinate sentence, release from prison with time limited or no follow-up) for one of a career as a mental patient (indeterminate sentence, conditional discharge, prolonged and indeterminate follow-up and supervision).

Diagnostic discovery is however frequently laden with dispute (Brown, 1995) and psychiatric illness is an area of medicine that is keenly contested to the extent that Crossley (2006) has demonstrated the emergence of what he calls 'social movements' to challenge the primacy of different views of mental

health and its treatment. It becomes necessary given the contested nature of psychiatric knowledge for participants to assert the credibility of their accounts. Aubert and Messinger (1958) have noted that any situation in which a person stands to benefit from withdrawal of role requirements as a result of illness labels will render those claims suspect. Put another way, the accounts offered in the interview talk of people on conditional discharge indicate that they are aware of social and cultural information suggesting that an illness designation arising after a crime has been committed may be questioned. As such their accounts are structured in such a way as to manage these competing accounts by describing the impact of symptoms upon their lives and by reference to authoritative support in the form of psychiatric or legal opinion, for these claims.

This analysis is not meant to suggest that admission to forensic facilities is one of conscious choice on the part of the person involved in an attempt to evade the punishment of a prison sentence. Rather it is that systems operate in ways that enable this process and social actors at institutional level agree the rules for entry and egress from this process²¹. For people with mental disorder and a conviction for serious offences, medicalisation is one available process by which means they are defined and addressed as being ill (deviant) and therefore requiring treatment rather than punishment. It is likely that social actors are aware of competing processes and therefore competing accounts. The narrative extracts used in this chapter demonstrate that this awareness may be embedded in the accounts of participants. These accounts include notions that mental health diagnoses provide a 'soft' option for offenders who might feign illness to avoid the sanction of prison. Indeed the discipline of psychiatry itself pathologises what it calls 'malingering' into several diagnostic categories which feature as differential diagnoses in court diversion programmes (WHO 1992; Rogers et al, 1998). The purpose of

²¹ It is recognised here that what Michael Lipsky (1980) refers to as street level bureaucrats may further interpret centrally agreed institutional rules and guidance. However I mean something slightly different in this context. I am suggesting the some rules based on disputed epistemologies are widely known within certain social situations or social groups and therefore stories that are offered are required to account for these disputes.

these diagnostic categories is to distinguish between those with identifiable mental illness and those who may wish to benefit from such a designation.

The stories told by the conditionally-discharged demonstrate awareness of other possible claims and move to negate these by establishing their own moral claims to patient status. The stories frequently invoke official warrants, in the form of medical diagnosis or official opinion, to establish claims to be treated as ill and therefore not liable to be held fully responsible for their actions. These warrants substantiate the claim to patient status and, in the context of mitigation for their actions or in handling the potential socially sensitive identity threats that might be otherwise available, they represent a necessary and perhaps required element in the stories of the conditionally-discharged.

It is relevant to note at this point that labels of deviance are identity relevant. By this I mean that persons liable to be labelled as deviant may internalise the label, be expected to behave in identity relevant ways and therefore be seen to do so in those terms (Scheff 1966/1984). Labelling theory posits just such a scenario and Rosenhan's (1973) now famous study of pseudo-patients in North American mental hospitals ably demonstrates that negative labels access established interpretive repertoires of those providing care and treatment. Sue Estroff (1989) has also pointed out that people with serious and enduring mental illnesses such as schizophrenia come to internalise the label of schizophrenia through repeated negative interaction with the social world. The label of illness may be a necessary and at times useful one when accounting for how one came to be detained in a forensic mental health facility. However its continuing negative effects may prove undesirable in the longer term.

4.6 CONCLUSION

In this chapter I have shown that service-user participants show awareness in their accounts that entry to the forensic mental health hospital is liable to result in ascription of deviant identity, implying as it does both mental ill-health

and criminal conviction. One way this is accomplished in the talk of the conditionally-discharged is through constructing themselves as moral patients suffering the whims of an uncaring system in which the active social agents are the professions. The accounts provided by service-user participants demonstrate attempts to access taken-for-granted understandings of illness as a viable explanation for untoward behaviours. The accounts in some instances present disrupted biographies as being a personalised negative effect of this behaviour and in doing so they function to accomplish moral identity work. This moral identity work is constructed in the talk of participants with reference to sequences of uncontrollable external events in the form of social disadvantage or disease processes of illness. These accounts can be seen as a pre-emptive step towards achieving re-integration to community living. These can be read as explanatory devices in account making which function to mitigate claims of deviance. The accounts of people on conditional discharge show an awareness of available competing accounts and frame any claims in the context of significant biographical disruptions. Stories of illness function to do the work of smoothing a path towards acceptance and community adjustment.

In the next chapter I will show however that while claims to illness status are necessary in the telling of the story of entry to the forensic mental health system, they become somewhat troublesome as the person moves toward community living. The person leaving forensic mental health facilities is required to do different types of work as they seek to re-establish their place in the community. This work requires that earlier identity relevant aspects of the person be shed to enable the transition to a new sense of self and to claim newer identities.

CHAPTER 5: TIME AND RHETORIC: ACHIEVING CREDIBILITY IN ACCOUNTS

5.1 INTRODUCTION

The return to community living is one fraught with anxieties for the person, their families and the workers providing supervision and support. People leaving hospital are concerned about successfully living outside of hospital (Hamilton Russell and McGregor Kettles, 1996). Families are concerned about how best to provide help (Macinnes, 2000). Workers appear to be oriented toward preventing risk behaviours such as dangerous or violent behaviours (Dell and Grounds, 1995; Godin, 2004). Achieving successful community return is dependent on a number of inter-connected factors. These factors include the availability of social support in the form of reciprocal relationships. This has been noted as an essential part of successful community living which also reduces risk behaviours (Estroff et al, 1994). Securing social support may depend on managing identity threats, in the form of community responses, associated with criminal offending and mental illness²² (Roskes et al, 1999). Together these are crucial elements in sustaining community tenure when discharged from forensic hospitals. In this chapter I will present analysis of the talk of participants in relation to events following discharge. This chapter will build on my analysis in Chapter 4 to explore how stories function to accomplish identity in accounts of return to community living. My analysis will show how accounts are organised to display an awareness of competing versions of events. These can be read as one way of actively managing the threats implied by deviance labels.

In Chapter 4 I suggested that people labelled as mentally disordered offenders and detained in forensic mental health facilities may pass along a number of possible trajectories as they move through the system. In

²² Roskes et al (1999) have referred to the combination of mental illness and criminal offending as creating what they term a 'double stigma'.

exploring the transition to community living as told by participants in this study it appears there are at least two distinct but parallel processes. These are the situational move to community living and the dispositional transition the person must make. I am using 'situational move' in this instance to mean the physical relocation of the person from the hospital setting to a community setting. 'Disposition' in the sense I am using it here is not to be taken as some internal state of the person but rather the identity work the person engages in, in other words how the person accomplishes identity in their talk. I have outlined in Chapter 4 some elements of the dispositional transition which was accomplished in the talk in narratives related to admission to a forensic mental health facility. In this chapter I will extend this analysis to explore further the identity work accomplished in talk related to the move from secure institutional care to community-based living.

In choosing to focus on the move between institutional care and community care I do not wish to give the impression that this is somehow unidirectional. Some service-user participants had experienced setbacks in their expected discharge trajectories and others had experienced interruptions in the form of return to hospital. Participants were however asked to participate in this study to talk about their discharge from hospital. Many had experienced recall to hospital and indeed one of the data extracts provided here is from a participant recently discharged following recall to hospital.

In forensic mental health services, the situational movement between hospital and community is marked by both formal process events, such as mental health review tribunals, and by informal but nevertheless phased process events experienced by participants and recounted in their interview talk²³. For example, a series of phased periods of leave might be seen as a more informal everyday experience in the process of preparing to leave hospital. These periods of leave are nevertheless used by participants to signal progress towards increased liberty and eventual discharge.

²³ The phasing of leave from hospital is usually managed by staff on a titrated basis commencing with leave with one or two nurse escorts in the grounds of the hospital and progressing towards increasing periods of time with less amounts of direct supervision in the community outside the hospital.

The analysis of narrative extracts that I will present here focuses on conditional discharge, in particular leaving hospital. Leaving hospital can be a relatively straightforward process in most cases of ill-health. An everyday understanding of hospital discharge is that once a person has received treatment for their condition they may then return to home and work life with little or no further planning. Many of those detained under Section 37/41 of the *Mental Health Act 1983* however have lost their homes, their jobs and have become disconnected from their social networks. Arranging essential emotional and material supports can be difficult and will need new identity work to establish supportive networks. Discharge is also dependent upon a number of contingencies such as the availability of suitable accommodation. In some instances, elements of the aftercare package are provided by non-statutory agencies in the community who may have different scheduling requirements. Achieving successful discharge appears in part to hinge upon resolving discontinuities in the timescales of hospital and community. I will show how concerns with temporality and discontinuity were a feature of the talk of participants.

I will also show how temporality was used in accounts of the conditionally-discharged to achieve identity claims of recovery and credibility. More specifically I will show how complaints about discontinuities in hospital and community time, provided the space for identity talk that was rhetorically organised to achieve claims of fact. In particular this talk appeared to function as a means of challenging or rebutting competing versions of events.

In the previous chapter I have shown that claims to illness labels by people on conditional discharge in relation to their initial detention under the *Mental Health Act* are a necessary part of the story of entry to the system. These labels are claimed in stories and functioned to warrant absences from particular social requirements. For instance, they establish claims to diminished responsibility status in both legal and social settings. During the initial period of hospital discharge these labels continued to be claimed and were necessary as a device for explaining ongoing absences from expected

social roles. It was certainly the case that workers continued to impose and reconfirm the illness label in their expectations of access to provide aftercare and supervision (Scheid-Cook, 1993). People on conditional discharge have expressed the view that the level of aftercare and supervision should ease-off over time and eventually stop (Dell and Grounds, 1995). In this chapter I will show how talk of leaving hospital accomplished the continuing identity work necessary to establish the narrator as a credible, moral social actor. I will suggest that this talk functioned to demonstrate the achievement of transitional identities. Claims to newer identities are established by creating distance between the categories set in play by social control agencies following the offence and the category-relevant descriptions in use in the interview talk of participants.

Data from the research interviews includes stories told by service-users of their return to community living which describe varied experiences of attempting to re-integrate and achieve socially valued roles. These include process events such as formal and informal stages in return to community living which enable or facilitate access to variances in arrangements for aftercare. These accounts included talk of the duration of detention and aftercare, sequencing of movements through phases and timing of key events.

All service-user participants described a staged process of gradually increasing levels of parole,²⁴ from the forensic mental health facility, leading up to their conditional discharge. These periods of leave were usually granted by the clinical team and sanctioned by the Home Office following a request from the Responsible Medical Officer. Skelly (1994a) has noted that service-users construct these paroles as 'stepping stones' toward eventual discharge and this notion of gradual movement toward leaving hospital was a feature of stories told in the current study. For example, one participant [SU10: Setting 2] noted that scrutiny by professionals of progress, as measured by

²⁴ 'Parole' is the term commonly used by both service-users and workers to describe the phased periods of leave spent outside the forensic facility. The term itself is reminiscent of that used in the prison system. Within mental health settings the term appears to be unique to forensic and secure facilities.

relationships with staff and other patients, was seen as an important marker in gaining parole. This was described as a rehabilitative strategy of teaching daily living skills with the intention to 'slowly integrate you back into the community' (line 197). Roth (1963) has noted that there is a form of benchmarking undertaken by people awaiting discharge from hospital in which expectations of progress are associated with gaining of certain privileges over time. The main concern here appears to be an attempt to establish regularities with regard to timing of discharge phases. A number of participant's stories retell events in which they sought to bargain with staff to establish timetables for discharge (for example, see Niall's account below). Others compared themselves with people who had successfully achieved discharge, as a way of determining an approximation of how long they should be detained. These accounts suggest a form of benchmarking, in which normative temporal ordering of the social world is devised by participants in interaction (Bergmann, 1992).

Workers described the use of paroles in a different way. They portrayed parole as managed risk-taking, that is, it allowed greater levels of freedom to assess how well the person managed and performed the rehabilitative tasks necessary to return to community living. The assessment by workers of the success or otherwise of this parole status was an important determining factor in decisions to progress with discharge planning. Patients and workers may experience time differently leading to perceptions of scheduling delays (Klitzman, 2007). Scheduling delays may be read as discontinuities between patient and staff time and can be further exaggerated by differences in hospital and community time (Heaton, 2001).

The decision to conditionally discharge the person was in many instances made by a Mental Health Review Tribunal. This is an independent judicial review process through which detained patients are entitled on application to request an examination of their continued detention. The Tribunal has the power to direct the discharge of a person once the statutory criteria for discharge have been met. The decision to direct the conditional discharge is

based upon evidence supplied by the patient's clinical team, a second opinion from another psychiatrist and representations from both the Home Office and the patient's legal team. The tribunal can direct the person to be discharged immediately, refuse discharge or defer discharge until it is satisfied that appropriate aftercare arrangements are in place. This can be a time of great frustration for people waiting to leave hospital after years of detention. Stories told by participants devote considerable space to notions of time passing, time served, assessments of timings related to moving from one phase to another and anxieties surrounding this process. In particular, there commonly appeared to be a putative association between time passing and perspectives of the direction of travel toward greater or lesser independence from mental health services.

5.2 "I WASN'T EXACTLY UNDER LOCK AND KEY, BUT I WASN'T FREE": TIME AS IDENTITY-RELEVANT TALK IN LEAVING HOSPITAL

A common and perhaps unique feature of stories is their ability to address the passing of time and the sequencing of events. This may have something to do with stories providing the means of placing the individual within a wider social system (Bergmann, 1992). For instance, Torre (2007) has noted in an analysis of work time and family/personal time that there are commonalities in the talk of social agents in relation to the temporal elements of their narratives. These commonalities include widespread time metaphors used in talk. One commonly used time metaphor suggests Torre (2007:176), is time as a horizon of action intentionality. This is the way in which reference to time is used to indicate the intentions of social agents through the use of narratives that connect past and present with future expectations. Torre (2007) sees the use of time metaphors in talk as one way of constructing meaning and identity

through narrative²⁵. Time as a horizon implicates a type of cognitive patterning in which contemplation of past or conjecture of future events from the position of the present standpoint “provides the temporal horizons for social action” (Torre 2007: 176). This suggests that social actors not only derive understanding and meaning from their lives through temporal narratives, but that these understandings make social action possible. Zerubavel (1976:89) has previously suggested that time is an important missing aspect from sociology and that;

“The main sociological objective should be the unveiling of regular patterns of association between social events and relatively standard durations”

A focus on time in the accounts of social actors may reveal this temporal patterning of social life.

Stories provide the means to relate fragmented occurrences across time and contribute to the formation of identities. People with severe and enduring mental illnesses create temporal models of the experience of illness (Barker et al, 2001) and this experience is known to signal particular social identities (Goffman 1963; Estroff 1989). In Chapter 4 I have shown how stories of illness are used to account for past dangerous behaviours as biographical disruptions. Narratives are a way of achieving coherence and direction across time and are seen as contributory to the historical emerging self. Gergen and Gergen (1983) have argued that people are reflexive and diachronic. Diachronic refers to the historically emergent part of identity, known as the self. At a rudimentary level narratives can be progressively or regressively directional. Progressive narratives answer reflexive identity-relevant questions such as, “am I improving?” Regressive narratives also answer identity-relevant questions for instance, “why do I always get things wrong?” Gergen and Gergen (1983) suggest that progressive and regressive narratives imply directionality. This is how the person sees themselves

²⁵ Torre goes further to suggest that the construction of meaning and identity in narratives commit social actors to act accordingly. I am less sure on this point and instead choose to see talk as produced for the purposes at hand and identities deployed to meet changing situational demands as suggested by Antaki et al, (1996).

across time. From this perspective the presence of directionality in the temporal quality of narratives is also an identity function. Stories of movement towards discharge from hospital to home indicate progressive directionality and as such may be an important feature in identity work in talk.

Although there may be other potential narratives that the person can employ to achieve identity work in their talk, Gergen and Gergen (1983) argue that for cultural reasons these are limited to set repertoires, for instance for reasons of social utility. One example of the social utility of particular repertoires can be seen in the use of vocabularies of motives to explain actions (Mills 1940).

Mills (1940) indicated that motives appear in talk under particular conditions such as when people are called upon to offer accounts which aim to persuade or dissuade imputations in interaction. Research interviews may function as sites for the production of account repertoires that seek to address particular common concerns, such as chronicity or the supposed intractable nature of mental disorder and criminality. In talking about discharge from forensic mental health hospitals, narrative repertoires appear to centre on progressive accounts albeit with numerous disruptions. The temporality of these narratives function to place the person within society, assert particular identities and establish claims to directionality. Directionality in the talk of the conditionally-discharged may then function to achieve transition from previous illness identities towards newer identities of recovery.

The extract presented below is taken from an interview (lasting approximately one and half hours) with Niall who I gained access to in research setting two. The interview took place in the living room of the supported house where Niall had been living for 2 years since his conditional discharge. Niall's discharge had been delayed due to a lack of suitable supported accommodation and he opened the interview by responding to the prompt to talk about his preparation for leaving hospital. In this extract Niall outlined the experience from his perspective of waiting for a Mental Health Review Tribunal and his eventual deferred conditional discharge.

- 1 MC: I am interested in hearing about your time in hospital and preparing to leave
2 hospital and what has happened since leaving hospital. I would like to hear your story
3 really.
- 4 R.: Righty-o
- 5 MC: maybe from when you first knew you were going to leave hospital
- 6 R.: Um, well (1) I did have a umm I'd a tribunal booked for August 2002 and because
7 they didn't they couldn't find me a place to actually be discharged to I had to adjourn
8 the umm the tribunal (2) and it wasn't like until four months after that, something like
9 December (1) before I did get discharged and I mean four months is (1) you know it's
10 a long time when you know that uh everybody in the team is and the doctors are
11 agreeing that you should be gone (1) and umm its quite hard like you know. (1) I
12 mean I did have all the paroles, the unescorted paroles but I mean I wasn't exactly
13 under lock and key but I wasn't (1) free anyway you know and umm I did find them
14 found them to be a bit rigid (1) because they were stating that um they would only
15 allow me to be discharged into a 24 hour hostel, staffed 24 hours and umm (2) and I
16 said, you know the position I'm in can we be a bit flexible on it and they weren't
17 having any of it (3) so (2) I had to like I say I had to adjourn one tribunal and then
18 umm (1) in the meantime while all this was going on my, I was shown eleven places
19 including this altogether, yeah unbelievable. I even had a look at a place in [distant
20 rural town]
- 21 MC: Wow, right
- 22 R: And you know [RSU] is in [local town] so
- 23 MC: So they looked quite far away for you
- 24 R: Yeah, but trying to find an empty bed was (2) you know (4) and I mean I was
25 being shown places and (1) they, well much to say they weren't like this you know
26 and I was still chomping at the bit to (1) try to get my foot in the door anywhere you
27 know. (7) I went to one place in [small rural town] and I had to sit before a panel,
28 yeah, there was about five people on this panel asking me questions and yeah (2) and
29 they done that on the points system and I missed the bed by a couple of points or
30 something, yeah. (6) So like I say yeah August it was and I had the tribunal and I had
31 to have it (2) adjourned then 'til November and December the 11th when they finally
32 found this place like. This come up and I didn't know about it until the day before (2)
- [Niall interview: Setting 2: lines 1-32]

Both temporal and sequential ordering of events is a common feature of narrative structure. In Niall's account the sequencing and temporality were intertwined so that his story unfolded in an organised pattern. This attention to linear time-lines and orderly sequencing of the story functioned to establish a convincing and credible account. He located the time of his story at the outset of his turn in line 6 and his narrative unfolded as a sequence of events leading up to his eventual discharge. This initial orientation indicated the time and situation in which the story was to be heard. The events marked by a Mental Health Review Tribunal are anxious moments for someone on a Section 37/41 as in the vast majority of cases there can be no conditional

discharge other than through this route. Adjourning the Tribunal can then be seen as an unsatisfactory outcome and responsibility was apportioned in the story to account for this. The unidentified 'they' who were charged with locating and securing suitable accommodation were mentioned six times in these opening turns. It was to be understood that 'they' were to be held responsible for the delays in his discharge due to a failure to secure suitable accommodation. In line 7 Niall's talk featured a softening of his position as he repaired his initial accusation of direct culpable blame; "they didn't" was repaired with an immediate "they couldn't". In these opening lines Niall positioned himself as the injured party deserving of the sympathy of the listener. An unfounded accusation at this point in his account indicated by "they didn't" may have undermined his appeal for a sympathetic listener. The quick repair, "they couldn't" allowed his story to continue, implying that rather than simply not looking for accommodation the responsible persons were less culpably unable to find a suitable place.

Niall retained his critical stance towards those he saw as preventing his discharge and labelled them "rigid" indicating that a more permissive approach would have been preferable to him [line 14]. Later in this extract [line 29] there appeared to be a further softening of blame when Niall mentioned the use of a points system by housing panels to determine suitability for placement. The reference to a formal, and what might be viewed as a mechanistic, process rather than an interpersonal one also functions to indicate that difficulties in gaining suitable housing placements in the form of refusals should not be understood to directly implicate the identity of the speaker. That is, the failure to secure accommodation can be seen to be a consequence of external factors rather than directly implicating Niall as an unsuitable person.

Niall opened his story differently to some other participants in that he focused on the delay in leaving hospital and by implication he indicated that responsibility for this delay laid elsewhere, that is, outside of him. The sense was that he had served his time and arrangements should have been in place

for his discharge. This sense of serving time was one that was evident in a number of the interviews in this study and indicates identity-relevant directionality. In this account directionality appears to function to show that the speaker was to be seen as recovered, no longer ill and therefore a credible rational narrator. Niall's account provided an example that was representative of the sample in this regard.

In opening his account Niall made no reference to illness or treatment for illness, the only allusion was the reference to 'doctors' in line 10 and his reference to being 'discharged' [lines 7, 9, 15]. His language in these opening lines appeared on closer inspection to use terms which may be synonymous with the prison system and having served a sentence. Constructing detention for treatment as time served was not unusual among participants and perhaps is related to the experience of receiving a criminal conviction in a Crown Court for the original offence. Put another way, if an actor has the experience of a public criminal trial they may position their time spent within the system as a 'sentence' rather than detention for treatment. This allows claims to identities related to that of rehabilitated offenders which may be seen as qualitatively less stigmatising than that of a discharged mentally ill person. Birmingham (2003) noted that prisoners with mental health problems are spoken of pejoratively, are vulnerable to discrimination and will attempt to keep their condition hidden if at all possible. Accessing culturally available understandings of having paid the price for the criminal offence in the form of a completed sentence may be one strategy available to conditionally-discharged people in negotiating new (although status-wise perhaps only marginally improved) social identities.

There are however crucial differences between sentencing for criminal offences and detention for treatment not least of which is that detention for treatment is indeterminate, there is no set tariff of time to be served. For some, the time spent in hospital care will be less than might have been expected if a prison sentence had been passed for the conviction, but for

others the time spent in treatment is considerably longer²⁶. Niall's talk used the language of both criminal justice and forensic systems, for instance he referred to "paroles" [line 12], "lock and key" and also to being "free" [line 13]. The forensic system shares much of its language with the prison system. This is perhaps related to the staffing of high security hospitals by members of the Prison Officers Association, who patients refer to as 'screws'. The language is also designed to be ambiguous, because as terms are understood to apply to both types of setting they can be deployed for particular effects. Niall's story functioned to construct notions of having served his time and perhaps also indicated how he would like this time to be seen to have been served. The almost complete absence of illness talk suggests that he saw little value in an illness label two years on from leaving hospital and was instead oriented towards a view of himself as someone who had completed his sentence.

Reference to time is perhaps not surprisingly a feature of the talk of people on conditional discharge. Direct reference to time spent in hospital, prison or on conditional discharge in the community and indirect reference to the experience of time in relation to service provision and the degree of control the person has over scheduling of decisions, were made in the talk of participants. Niall's account was concerned with a relatively short period of time that is the four month delay in finding him suitable accommodation. He referred to this period later in the interview as "the longest four months I spent down there" [line 54] and "definitely it was a long four months" [line 66]. References to time appear throughout his interview and include talk about the time spent in hospital, time spent since leaving hospital and the time deemed necessary to have lived in the community before one might apply to a Mental Health Review Tribunal for an absolute discharge. In each case the focus was on directionality and progressive narratives.

²⁶ I encountered a comparative example of this when I interviewed a man who had spent 20 years in a high security hospital for the offence of threats to kill, while others who had convictions for more serious offences such as homicides had spent less than 2 years in medium security hospitals.

Niall's focus on the delays incurred in leaving hospital may at first glance appear disproportionate when set against the length of time he was detained or indeed the length of time he might have continued to be detained. It was perhaps his lack of control over decisions regarding the scheduling of his discharge and the impact of these on the schedules of the individual that was being highlighted (Roth 1963). It may also be seen that this delay was in effect a disruption to his expected trajectory of progress toward discharge. Heaton (2001: 101) notes that there are discontinuities between hospital and home-based care, incompatibilities between the time frames of hospitals and home and a lack of synchronisation between service and user requirements. Having no say over the possible length of his detention and having no time target to orient towards, Niall's lack of control over scheduling was emphasised. His expectation of discharge was one which was more akin to acute hospital stays where the discharge process is more standardised and perhaps more immediate, or indeed prison sentences where a prisoner has a set release date. This was shown in his talk on lines 10-11 where he argued that the doctors had "agreed you should be gone" and his readiness to leave hospital was emphasised in line 26 when he said he was "still chomping at the bit".

Conditional discharge is often phased over a period of time and determined by multiple factors including judgements about the risk the person may pose (Mason and Mercer, 1999; Heyman et al, 2004). Heaton (2001) has noted that for people with physical disabilities discontinuities between hospital and home timeframes have caused delays in securing properly prepared discharge environments leading to discharge plans being only partially implemented. Where the conditional discharge of people from forensic hospital is concerned however it appears that these discontinuities result in the person spending longer in hospital than is indicated by their condition or their risk status. Hospital detention on Section 37/41 is by its nature indeterminate and a delay at a time when discharge seems possible must be particularly frustrating.

The indeterminacy of the order for detention and treatment appears to be a problem to be addressed in the narrative of leaving hospital. By this I mean the story must also deal with any decision to allow discharge and do so in such a way as to indicate that this decision was not taken lightly. Court decisions on detention and treatment are based on a view of the condition as being of a nature and degree to warrant sustained psychiatric treatment, the outcome of which cannot be reliably predicted. The story in this extract functioned to account for the decision to discharge the person from hospital. This decision was one that was legitimised by reference to the Mental Health Review Tribunal and the agreement of “everybody” in the team [line 10]. It was to be seen as a serious and formal undertaking which ratified the suitability of the person to return to live in the community. This ratification was reserved however in the sense that it was not possible for the person to return to just anywhere. This was supported in lines 14-15 when Niall outlines that there was to be no flexibility in the decision related to the level of supported placement thought suitable for his needs. A particular view held by the clinical team of what was deemed appropriate discharge accommodation, was implied in Niall’s account. It is a view that is predicated on securing more subtle forms of scrutiny and monitoring of discharged people by agents external to formal health and social care services.

Supported housing has become an important and crucial element in the transcarcerative system of mental health care (Arrigo, 1997, MacPherson et al, 2004). Much of this housing is provided by voluntary charitable groups, housing associations and increasingly for-profit businesses that have identified particular market niches. The range of supported care encountered during the course of this study illustrated the significant role that these organisations are playing in the aftercare and supervision of people from forensic mental health facilities. Supported aftercare placements range from those providing individual twenty-four hour supervision with a member of staff always with the person both in the placement and outside in the community, to various levels of decreasing support leading to eventual independent living.

Supported placements were constructed by workers as a form of proxy supervision, and a useful source of information for formal aftercare services. Movement between various sites of contact and scrutiny by housing and voluntary sector workers forms an important part of the strategy for aftercare employed by workers. Supported placements have also become de facto discharge and risk management policies in Wales in the light of recent failures in follow-up and aftercare arrangements for people on conditional discharge (Cardiff Local Health Board, 2004). Niall's claims of rigidity and inflexibility on the part of services may be a reflection of newer contingencies brought about by external pressures for more risk averse strategies in discharge planning. In effect the risk escalator for discharge was being extended beyond the walls of the hospital and into the community. This extension was not simply based on assessments of individual risk as indicated by Heyman et al, (2004) but envisaged as a more widespread and standard approach for application to all conditionally-discharged people from forensic mental health services (Cardiff Local Health Board, 2004). This elongation of the risk escalator has a significant effect on attempts to reconcile problems of time and sequencing in accounts which seek to function as progressive directional stories. Niall's account described dissatisfaction with discontinuities in discharge. His talk can be read as establishing a kind of muted resistance to the more powerful system that employs workers. However over the course of the research interview his talk demonstrated movement toward an accommodation with the contingencies of conditional discharge.

The phased nature of conditional discharge is evident in Niall's account as he outlined the plans as he saw them to provide gradual 'step-down' aftercare from the hospital team. As the following extract shows, Niall's story is organised to achieve a positive directional account of his move from supervised living towards the relative independence of renting his own flat.

10 R: Yeah, umm (1) what it was, when I first came here it was on the understanding that
11 umm I didn't I wasn't going to have to stay here very long. I think they
12 acknowledged that fact but you know they were adamant that I had to come here first
13 so they said what we'll do is um we'll do a, because I'm on a 37/41, they said right
14 we'll umm we'll follow you up for six months initially and then we'll hand you over

115 then to [local hospital] should you still be in the [city] area (3) so I was told that I you
116 know I would only probably stay here six months and if it was probably anywhere
117 else it would have only been six months but I've been having the life of Riley here
118 you know, it's been good. So I had a umm a CPN, social worker, I seen the
119 consultant once every couple of months, 117's which I still see now but I had it from
120 the [RSU] for six months and after that then it was [local hospital] like. And all that's
121 going to change again after next week so.

[Niall interview: Setting 2: 110-121]

This extract demonstrated Niall's focus on time and its importance in charting his move away from custodial care. This was marked by a fixed period of time elapsing (6 months) and the transfer of his care from the forensic medium security service to the local hospital forensic team. Time was also an important signifier of rehabilitation and moving to levels of more independence. The longer interval spent in supervised accommodation which might imply untoward or unexpected needs for continuing care is resolved on line 117 with Niall's claim to have been "having the life of Riley" in this placement. The continued input of health and social care workers functioned to show that the speaker has complied with the requirements of his discharge order and can be understood as authorising his move towards greater independence. This was signalled by the speaker in line 121 that all was about to "change again after next week" when he was due to move to the relatively more independent setting of a rented flat. The account constructed a view of an unbroken continuum between compliance with rehabilitative processes in the form of monitoring, and greater independence in the form of liberty from this level of continued scrutiny.

This view of time as an important signifier of the rehabilitative process was also evident in the interview talk of both Niall's social worker and the community psychiatric nurse. The social worker described, in the extract below, her perspective of the different phases of discharge and the importance she placed on the timing of these phases.

5 MC: Perhaps you could start from when you first encountered him.

6 R: Well I suppose I first (1) because [Niall] of course is not a [city] boy as it were,
7 he's a [rural town] patient, so I first encountered him at a I think sort of the (2) at a
8 discharge 117 at the [RSU] where basically I was sitting (1) listening and I took over

9 as his social supervisor (1) and at that point we were jointly managing him for the first
 10 6 months with the [RSU] staff and (1) in fact I only saw him monthly (3) partly
 11 because (1) with a CPN and social worker from the [RSU] and a CPN and a social
 12 worker from [city], it's like a visitation rather than a (1) or inspection rather than a
 13 visit so we we sort of tried to space it out a bit really. (3) And (2) I have in my
 14 memory and I can't check that but it may have been the full 6 months before [Niall]
 15 was handed over or it may have been slightly shorter than that (2) and I think in one
 16 sense we always from the beginning we found [Niall] (2) thought-provoking I think.
 17 He actually worried us (2) but because he is actually so incommunicative. (8) [sighs]
 18 And I think when we first took over (3) his first CPN was [first cpn] and I think by the
 19 second visit [Niall] was saying he didn't like [first cpn] (2) which we actually found
 20 staggering because (1) [first cpn] is not only one of our most experienced nurses but
 21 one of the nicest and gentlest (4) umm nurses we've got (4) so I think [second cpn]
 22 took over (3) and [second cpn] unlike me she went on one occasion by herself because
 23 sometimes we tend to alternate visits rather than always having joint ones if there's no
 24 risk reason, she went down to see [Niall] and she got a real gut feeling of worry (6)
 25 which I have to stay I have never, ever, ever felt with [Niall]. I have never felt
 26 personally threatened worried (1) you know the sort of gut feelings you can
 27 sometimes get with people for no reason at all. (1) And then [third cpn] took over and
 28 it's settled since then and we rather wondered if actually (1) if actually [Niall] is more
 29 interestingly more wary of nurses (1) than he is of social workers. Umm not quite
 30 sure why. He also umm almost as soon as the [RSU] stopped (1) their supervision, he
 31 actually wanted to reduce the visits (2) to monthly (3) which we felt was much too
 32 soon for somebody who'd only been out of medium secure for six months (2) umm
 33 and we managed to achieve a compromise with that. We in fact said no we have to
 34 carry on seeing you fortnightly in fact some people would argue that a 37/41 should
 35 be seen weekly (2) umm we have to see you fortnightly but we offered him a six
 36 weekly outpatient appointment with the RMO (2) rather than a monthly one. Umm
 37 [drinks her coffee] which is I think we sort of achieved a satisfactory compromise
 38 with that. I think I think part of the reason was [Niall] (2) [Niall] at that point sort of
 39 saw his progress in terms of a lessening of supervision (3) and, and I think maybe he's
 40 now worked it out that umm progress is not so much a lessening of supervision but
 41 getting the MDT to say I will support you for an absolute in due course. I think he's
 42 worked that out. (7) [drinks coffee] should I just carry-on?

[Social Worker: Setting 2: lines 5-42]

The focus on time passing is one element of the way in which participants accounted for movement through the system. Parallel processes of assessment of potential future risk behaviours are more implicit in the talk of workers than service-user participants. Put another way, workers refer to risk assessment as being an important part of their role and as such it may be that this functioned in their talk to signify one part of their occupational identity. Service-users placed less emphasis on risk behaviours in their talk perhaps because this sets in play particular identities which are open for negative social labelling.

The assessment and prediction of risk behaviours of people with mental illness is a notoriously difficult and inexact science (Monohan, 1988). The social supervisor implied here that achieving accurate understandings of potential risks was something that would emerge over time. Clinical and actuarial approaches to risk assessment tend to place great weight on historical factors to the extent that the phrase 'nothing predicts future behaviour like past behaviour' has become a rubric for many risk decisions in mental health practice (Ritchie et al, 1994). Current thinking suggests however that an emphasis on non-changing historical factors must be weighed against assessment of dynamic situational factors (Webster et al, 2002). In this extract the social supervisor constructed the phased approach to Niall's discharge as a form of rational decision-making. As time passes and no untoward events occur the probability of further risk behaviours may be deemed to diminish to the extent that he would be supported "for an absolute in due course" [line 41].

Niall's account of staged return to community living typifies the collected accounts of people leaving hospital for the first time on conditional discharge who participated in this study. The provision of aftercare was substantially weighted towards material aids such as providing suitable accommodation, and to a lesser extent emotional and social support needs. Conditional discharge is considered to be a successful approach in that approximately 75% of people conditionally-discharged from forensic mental health services maintain their community tenure successfully for at least the first 2 years (Home Office, 2007) and the vast majority do not commit further serious offences (Gibbens and Robertson, 1983). An analysis that focuses on actuarial calculations of risk however appears to cloak some real tensions within the provision of conditional discharge aftercare that are revealed in the talk of the people involved.

In the next section I will show that discontinuities between hospital time and home time as constructed in the talk of service-users suggest real problems in securing the required material and socio-emotional needs for people leaving hospital on conditional discharge. Given that conditional discharge is phased and that discharge plans are scrutinised by an independent panel in the form of the Mental Health Review Tribunal, it seems surprising to find that service-users talk about difficulties in arranging for both their material and socio-emotional needs. One might expect that something as formal sounding as a discharge plan, or aftercare package, would address a range of health and social care needs. I will show how the discontinuities between hospital and community provide the context for talk which also functions to accomplish particular types of moral identity work for social actors.

5.3 “IT’S A HELL OF A STING IN THE TAIL”: DISCONTINUITY AND SOCIAL SUPPORT

To a certain extent the claimed success of conditional discharge may be seen to be related to the powers of compulsion that extend beyond hospital and into the community (Sensky et al, 1991). The return to community living on conditional discharge is one that remains subject to review and revocation. Section 37/41 allows for the recall to hospital of a person on the grounds of mental deterioration, concerns about risk behaviours or failure to comply with the conditions imposed upon their discharge. Readmission as a result of recall is often significantly shorter than the initial detention, unless the reason for recall is related to behaviour which is likely to result in further criminal charges. That said, detention following recall can be prolonged and discharge delayed beyond the point at which a person would expect discharge, such as when their condition had improved.

Delays encountered in discharge appear to centre on administrative issues in promptly arranging Mental Health Review Tribunals²⁷. Mental Health Review Tribunals can take months to arrange and require second medical opinions to be sought as well as reports from medical and social care teams. In some cases the Home Office may exercise their right to participate and seek further opinion and representation at the meeting. This can prolong the process and is often a source of frustration to the person waiting to leave hospital. Delays also occur when discharge plans are not considered suitable or robust enough to provide the required level of aftercare support and supervision. As I have argued this may in part be due to discontinuities in schedules between hospital and community. Service-user participant accounts indicated that discharge plans sometimes fail to address the range of needs necessary to facilitate their social re-integration. The emphasis on gaining suitable discharge accommodation is a material and concretely practical task for clinical teams. The potential benefits that can be derived from the provision of mental health care in the community (Stein and Test, 1980) and expressly preferred by users of services (Hobbs et al, 2000; Newton et al, 2000) are challenged by hospital and community discontinuities.

The extract presented below is taken from an interview (lasting approximately one and half hours) with Bryn who I gained access to in research setting one. Bryn was a man in his thirties who had a history of detention in psychiatric hospitals, forensic mental health facilities and prison. I had been advised by the Responsible Medical Officer to see Bryn, “at a neutral venue as opposed to seeing him at home”. The reason given for this was due to his legal status. I discovered during the course of the interview that the clinical team declined to visit Bryn at home ostensibly for safety reasons and that he was unhappy with this. The interview took place at his suggestion, in the outpatients department of the medium secure unit where Bryn had attended a weekly appointment with the clinical team. Bryn commenced his story like many others in this study by first recounting his admission to, and his experiences

²⁷ For people detained in hospital on Section 37/41 of the Mental Health Act 1983 there is no parallel route to discharge beyond a request by the medical team to the Home Office seeking that they direct the discharge. While this alternative route is technically available, in practice it is rarely used and Mental Health Review Tribunals are the preferred route to seeking discharge from hospital.

of, hospital. Bryn had recently left hospital following a formal recall (which he very much disputed) ten months previously. In this extract which followed on directly from his story of admission, he retold the problems he had in achieving a smooth transition between hospital and home. This appears in part to be related to his hospital admission to geographically-distant services contracted to provide inpatient care but not continuing or aftercare responsibilities. The disputed nature of his recall and hospital admission however remained relevant in the following sequence of talk.

77 MC: So were you conditionally-discharged from [medium secure hospital] or were
78 you back here at [that stage]
79 R: No, no] from [medium secure hospital] yeah, well what's wrong with that you see
80 in my opinion is where the eight months I spent locked away um social workers (1) in
81 London and [medium secure hospital] (2) umm were saying they were sorting my
82 housing benefit out and there was no problem with this no problem with that (1) but I
83 came out to a lot of bills (1) you know two and half thousand pounds altogether well
84 two thousand three hundred (1) of electric arrears, gas arrears, rent arrears umm (1)
85 the water board, [bank] had been paying the water board without my permission (1)
86 and they wanted five hundred pound off me so a lot of pressure. Also umm (2) you
87 couldn't actually make any kind of claim for benefit until the judge had said yes
88 you're conditionally-discharged so then the person in the hospital could send a letter
89 to the social. Well (1) luckily for me it wasn't a Friday because previously I'd been
90 released on a Friday and by the time you get the tribunal over with it's in the early
91 afternoon if you're lucky. So by the time you get back to where you're living umm
92 and go to the social the social's closed. So then you got Friday, Saturday, Sunday and
93 Monday with no money, no food, no electric, no gas, now it's kind of a contradiction
94 really because one minute you're in hospital being cared for so to speak you know and
95 everything is done for you, you've support in (1) so to speak in every way that it
96 should be [cough] but then just to release you (2) with nothing you know and the next
97 time you see a doctor is a week later (2) it's kind of like it's a hell of a sting in the tail
98 you see you know. I mean for a lot of people who haven't got much or haven't got
99 nothing at all I mean (2) they couldn't be more of a higher risk in that initial three or
100 four days (3) to themselves or to society, there should be more stringent guidelines
101 and there should be more supervision initially be it umm home visits or whatever in
102 the first three or four days (1) because they're the worst they're the hardest days when
103 you get out the first week. Because you've got to get your benefits sorted I mean I
104 came out to two and half grand of a debt which I never had when I went in eight
105 months ago. See I wasn't given access to my flat initially you see until I had my
106 home leaves and then when I had my home leaves every time I went home I'd be
107 getting more and more bills which I couldn't pay, I didn't have the funds to and I
108 wasn't living there and I had to go back to hospital so my home leave was just picking
109 up bills looking around my empty flat well lovely empty flat and then having to come
110 back. Which is a hell of a wind up really you know especially when everybody and
111 their dog said I didn't need to be in hospital. (1) But because of the process (2) of the

112 tribunal there [cough] there's nothing you can do about it really is there until it's
113 done.

[Bryn interview: setting one: lines 77-113]

This account shows the discontinuities between hospital and home time and implicates the need for aftercare arrangements that go beyond help with particular types of material aid such as securing suitable housing. For Bryn the lack of opportunity to attend to aspects of his home life when he was detained, heightened the sense of discontinuity between hospital schedules and home schedules. Bryn constructed these discontinuities as resulting in debt which he himself was not free to address and which actively threatened the success of his discharge.

Bryn's account can be read as an attempt to achieve moral adequacy by implying limitations of the health and social care workers who have failed him. I am using moral adequacy here to refer to social action as an aspect of talk in demonstrating competence and adequate performance of actors. One way in which moral adequacy is achieved in narrative is through the telling of atrocity stories. Webb and Stimson (1976) have noted that atrocity stories are a feature of the talk of patients regarding their encounters with the medical profession. Atrocity in this sense refers to claims of poor standard, negligent or incompetent care. It is likely that the atrocity element of stories is not confined solely to narratives about medical encounters but more broadly to encounters with high status or powerful groups. People detained under the Mental Health Act, and dependent upon assistance to secure successful discharge, may view all professional workers as high status. That is, workers are liable to be included in such a category by virtue of the relative power they hold over the person detained. The contextual background may be relevant here. Bryn was recalled to hospital by professional workers and his discharge was dependent upon their agreement.

The types of atrocity stories told by people on conditional discharge appear to be similar to those characterised as moral talk by Baruch (1981). Baruch's (1981) study examined stories told by parents of children with diagnosed

serious illnesses and their encounters with the medical profession. A feature of the talk of parents interviewed in Baruch's study was the need to establish competence and rationality as a means to accomplishing their moral character as good parents in the stories they told. Moral tales in this sense can be seen to be a form of identity-work in stories. Atrocity stories function as moral tales in that they tend to characterise the patient as being the active rational agent struggling with the passive professionals' ineptitude in matters of central importance to their care and well-being. The production of atrocity stories at appropriate junctures in interaction is one way in which social actors demonstrate competence and belonging (Dingwall, 1977). In examining occupational boundary work of nurses, Allen (2001) has noted how these stories can demonstrate affiliation or disaffiliation with other groups. This is how the person positions themselves in relation to others. Atrocity stories may then be seen to have rhetorical qualities as they function to establish moral standing in situations of social friction.

I have shown in Chapter 4 how the talk of people on conditional discharge does one type of moral work, that of accounting for previous behaviours. Bryn's talk has some of the features of moral tales in that he constructed workers as having failed him in providing the required elements to enable the maintenance of his accommodation and sustain community tenure on discharge. To achieve this, his story functioned to do particular types of work, that is, to convince and persuade. I will show how some features of Bryn's talk functioned to do the work of positioning him as the authoritative and reasonable social agent attempting to take active control over his own discharge.

One way in which talk functions to establish moral adequacy, argues Baruch (1991), is through the device of constructing two separate realities in the story. These are the reality of the speaker 'I/We' and the reality of those who inhabit the medical world, 'they'. Each world is governed by different standards which define both the nature of events told and the expectations of performance by the social agents who occupy these different worlds. Bryn's account

constructed two worlds, that of the patient and that of powerful others such as social workers, the judge chairing the Mental Health Review Tribunal and 'the social' [line 92] who provide money in the form of benefits. Bryn's talk established the 'I/We' reality with a number of everyday aspects of talk. For instance in the opening line he identified a problem with the way in which his discharge had been handled, 'what's wrong with that you see' [line 79]. This was immediately followed by the phrase 'in my opinion' [line 80]. This functioned to indicate that the account was to be seen as a reasonable one, that the speaker was aware that other accounts may exist and what was being offered was one account categorised as the opinion of the speaker. In the opening lines [lines 79-86] Bryn established that there was a source of social friction present, a problem in how his discharge was handled. In doing so the personal world of the speaker was established at the outset of the story as providing the extra-situational context for the production of an account that was to be seen as both rational and authoritative.

Highlighting the availability of alternative accounts may create a problem for both the speaker and the listener however. It is a problem for the speaker if they are not seen to possess authority to speak on the subject. If it is just one opinion of other available versions then it may be heard by the listener as no more authoritative as the other versions available. The talk however was structured to attend to this problem. In the same line [line 80], Bryn indicated that he had the authority to speak by citing his experience, "the eight months I spent locked away". The citing of significant life experiences and his moral standing was a feature of his talk that was established before the interview had even commenced (see Box 5.1) and was reiterated numerous times throughout.

[Bryn] had just had an appointment with his RMO and wished to go outside and have a cigarette before we started. He insisted I join him and so we sat outside while he smoked and I made small talk but this did seem to help smooth the way for our later interview. [Bryn] described himself as not a bad person and would only do what many of the staff would do in the same situations. He told me, “there isn’t a rule I haven’t broken in places like this”. We talked about his car which he pointed out to me and told me some technical details, about which I confess I barely understood. He mentioned that he had been driving a much more expensive Mercedes which he says he bought when he was manic but couldn’t afford to keep and had now sold it. He says “when you are manic that’s what it’s like, you could have a hundred pound and spend it on food and be still hungry at the end of the day because you have given it all away.” He portrayed himself as friend to everyone and indeed while we sat outside in the beautiful sunshine [Bryn] greeted an elderly lady who was an inpatient and a member of staff stopped to chat with him.

BOX 5.1 Extract from field notes of meeting with Bryn prior to research interview

The account also constructed the alternative reality of the professional worker. The story functioned to present this in contrast to that of the personal world of the speaker. The account constructed the workers and perhaps more broadly, formal institutions such as the bank, ‘the social’ and the Mental Health Review Tribunal as having let him down. Bryn implied that the standards and expectations of the workers and the broader institutions which govern elements of his social life had not been met. Everyday expectations of health workers may include kindness, care, trust and compassion. Bryn indicated that he had certain expectations of workers. Workers were portrayed in Bryn’s talk as having misled him about his housing benefit [lines 81-83] and by offering reassurances which proved to be false [lines 83]. These complaints about workers were followed by a list of significant debts [lines 83-86] which were constructed as being a consequence of workers’ failure to attend to these matters, and which caused him ‘a lot of pressure’ [line 86]. The account moved on in line 89 to argue that it was a matter of chance that he had not left hospital on a Friday, which Bryn ably described

with reference to past experiences as being problematic [lines 90-96]. The talk here indicated that powerful others (professional workers) determined what happened in his discharge and were prepared to leave some elements to chance. These powerful others are contrasted with the rational reasonable speaker who clinches his argument by highlighting the contradiction (“it’s a hell of a sting in the tail”, line 97) he sees between hospital care and community isolation [lines 98-100].

Bryn signalled in lines 98-100 an implicit appeal to standards of the everyday world which he might reasonably expect the interviewer as a nurse lecturer to share. Hospital care is constructed perhaps in a somewhat idealised way as meeting all the needs of the person, “everything is done for you, you’ve support in (1) so to speak in every way that it should be [cough]” [lines 95-96]. The talk in these lines indicated that certain expectations of hospital care were held by the speaker at least for the purposes at hand. The story being told required the creation of the premise of comprehensive hospital care so that this could then be contrasted with what was about to be told. In the previous opening turn Bryn had described his hospital care as failing to meet his needs and this was signalled in his talk with the use of the conditional phrase ‘so to speak’. As I have indicated the formulation of hospital care providing for all one’s needs functioned to provide the stark contrast necessary to what follows, “but then just to release you (2) with nothing you know” [line 96]. The description of the move from secure supportive care to living alone with no money and no basic utilities, such as water or heating, is a bleak one. This contrast, having already been contextualised within the earlier lines outlining what are to be seen as problems with discharge, was convincingly accomplished.

The talk in this extract functioned to achieve both persuasive and ultimately conclusive arguments. One way this is achieved in talk is through the use of rhetorical devices. Discourse is pervasively rhetorical in that it orients towards alternative ways of describing things and seeks to agree, persuade, argue or challenge existing accounts. Edwards and Potter (1992) outline what they

see as a number of rhetorical devices which are common place in talk that seeks to warrant claims as facts. These rhetorical devices are used to enhance the plausibility of particular claims of fact or reality while rebutting counter claims. Bryn's talk demonstrated awareness of possible alternative claims and as I have shown his story managed these by establishing his authority to talk on the topics at hand. He achieved this by asserting jurisdiction based upon his experiential claims. However authority to talk may not be sufficient when alternative authoritative accounts exist. As a participant in this study Bryn was informed of the researcher's intention to seek the views of workers in relation to discharge and aftercare. His story therefore functioned to establish itself as a credible alternative to accounts provided later by workers. His account, provided to a nurse lecturer/researcher, appears to make ready use of everyday understandings of standards of care. Thus he was already oriented to the likelihood of further accounts being solicited and his account was rhetorically organised to address this. In the next section I will focus my analysis on the use of one such rhetorical device that appeared in this extract of talk namely, consensus and corroboration.

5.4 "EVERYBODY AND THEIR DOG": CONSENSUS AND CORROBORATION

The account offered by Bryn was an occasioned and situated account. It was offered within the context of an interview with a researcher external to the health and social care services providing him with aftercare. As such this may have provided the opportunity for the delivery of a particular type of rhetorical account. This account was achieved by constructing the speaker as someone with the authority of having lived the experience of conditional discharge and who could therefore claim jurisdiction to provide an account. It was also told to an interviewer who may have been seen to share notions of what constitutes good quality care. But the talk did more than this. Bryn's account included a primary complaint and a secondary complaint and as such it was also committed to achieving a convincing argument. The primary complaint

was that of the disputed recall and admission to hospital and the secondary complaint in this extract of talk was set within the context of how his discharge from hospital was handled. The primary complaint remained relevant as can be seen when Bryn cited wider agreement for his claim that his recall and admission were unnecessary [lines 110-111].

One way in which stories function is to describe events and to make the description of these events appear literal, particularly in relation to factual claims. In seeking to provide a factual account stories show awareness of competing accounts, they are structured to ensure that they are seen as something more than “a claim, a speculation or indeed a lie” (Edwards and Potter, 1992: 104). Description is used to do things in stories such as account for the actions of the speaker and the concerns of the listener. It also aims to indicate how the pattern of cause and effect should be understood. This according to Edwards and Potter (1992) is the function of description in accounts of fact, to establish that the version being told is the definitive one. How these accounts are assembled however is also relevant to how they function. The construction of accounts of fact includes devices that enable a version to be seen as “literal, solid and independent of the speaker” (Edwards and Potter 1992:105). The claim of independence is an important one in securing, through discourse, notions of consensus and corroboration.

Independent-ness or externalising establishes that a version is not simply for the purposes of furthering the speaker’s own interests. The claim of corroboration in the form of externalising is based on the everyday assumption that if something is claimed and supported by independent others it is less likely to be a fabrication. This is a useful rhetorical device in itself as it can also be used to undermine competing accounts. Where the story seeks to establish matters of fact, independence is a consensus warrant more specifically targeted to achieve rebuttal and to support these claims. Consensus functions and is structured rhetorically but it also is a ‘to-be-achieved’ construction for the discourse at hand.

Bryn's account was an authoritative one, accomplished through the demonstration of his knowledge of discontinuities of hospital time and community time in relation to claiming benefits on discharge. As such his talk established the grounds to be believed on this subject by reference to his knowledge of the system and how things work. The account was littered with detail in this regard making the narrative not only persuasive but more importantly plausible. This talk established at the outset the grounds for his secondary complaint, that of arrears arising from his admission to hospital which he had been unable to attend to. Bryn does the work of establishing his moral status as a good citizen who, if he had been free to attend to them, would not have allowed debts to accumulate.

The use of lists is rhetorically important in discourse across settings and is used to emphasise, demonstrate completeness and make claims appear conclusive (Heritage and Greatbatch, 1986). The use of lists and the claim to have experienced this scenario previously lend weight to the credibility of the description of recent events. The talk here however functioned to achieve support for the complaint and uses what Drew and Holt (1988) referred to as an idiomatic expression. This is a clichéd or proverbial expression that appears at specific junctures in conversation. In particular these expressions appear where a speaker is making a complaint and recipients are withholding support for the complaint. Bryn's use of the idiomatic phrase, "hell of a sting in the tail" [line 97] appears designed to provide a convincing closure to this part of his account.

The nature of the possible alternative accounts available was illustrated in subsequent research interviews with the community psychiatric nurse (CPN) and the social worker involved in providing aftercare to Bryn. It became clear during the course of these interviews that the community mental health nurse team were reluctant to provide aftercare support to Bryn ostensibly on the grounds that they did not see a need for nursing support. However it also emerged in the course of these research interviews that an earlier recall to hospital for Bryn had been prompted by what the nurse called 'threats to kill'

his previous community nurse. Within this context of claim, counter-claim and conflict the range of stories available to be told appear to derive from limited repertoires. These include establishing credibility and authority to speak on the subject of return to community living, perhaps to accomplish identity as moral agents. This implies decisional notions of whose account is to be believed or credited with more authority. Atrocity stories do moral boundary work in distinguishing between members of one group versus members of another. Bryn's account worked to accomplish an account in which he was let down by those providing aftercare services. The account of the nurse as we shall see countered this by providing an atrocity story of her own. Bryn was constructed as potentially dangerous and in doing so his moral character was directly challenged.

The extract provided follows on from a complaint by the nurse that Bryn had expressed a keen interest in having a CPN visit him on discharge, but that once discharged this interest disappeared to be replaced by a thinly veiled hostility toward the nurse. The account provided by the nurse in the selected extract below shows that at least one alternative account of discharge and aftercare was available and given that it was one that was held by powerful others, it may be seen to hold significant weight in the aftercare support arrangements for Bryn. We might assume it was known to him and that his account was oriented towards establishing his version as the credible and authoritative one.

66 MC: Did he explain the difference in his outlook from being very keen to being less
67 keen?

68 R: He (1) just (1) I think he just said he'd come out of hospital and he'd got so many
69 things to do he hadn't got time to sit here and talk. He didn't want people who he
70 didn't know going over his past. It was more to do with somebody he didn't know
71 umm he didn't want people he didn't know going over his past it was all documented
72 he'd been over it a hundred times before he didn't want to discuss anything that he'd
73 discussed in the past, he wanted to get on with his future and I think that was what it
74 was more about really rather than umm (2) not that I asked him much about his past
75 but it was umm I think he was concerned that I might (2) and he'd had problems with
76 his previous CPN so. (7) Do you know the situation with his previous CPN? I
77 suppose it's relevant. He'd umm made threats to kill his CPN and it had led to him
78 being recalled. They found ammunition in his house and he knew where she lived
79 and various other things so that was one of the reasons there was a reluctance for

80 CPNs to be involved really [laughs] understandably. (5) and that's one of the reasons
81 why visits take place here rather than at his flat (1) and the tribunal had directed
82 where we see him at the moment, they want the care plans to stay as they are so from
83 the Home Office. I think [social worker] said she's never known a tribunal go on for
84 so long and be so specific in their requests. They asked us to change something in the
85 care plan, it said [Bryn] should attend the [RSU] and they wanted it to say [Bryn] will.
86 So they wanted it to be far more specific than it actually was (11) I think it changes
87 (1) from week to week with [Bryn] though, some weeks he's he's you know he wants
88 to see a CPN some weeks he doesn't. I think it's unusual because the CPN is
89 normally the person that people want to see because we don't report to the Home
90 Office so (1) I think he knows he has to see [social worker] and [RMO] and probably
91 now I'm just somebody he doesn't have to see so why should he. I think there is a bit
92 of that there but normally in my experience people are keen to see the CPN because
93 they're the one that's not reporting to the Home Office. I don't think [Bryn]'s of that
94 mind I think he's (2) doesn't particularly want to see anyone extra (2) you know he is
95 quite happy to see [social worker] and [RMO] because he has got to see them (20)

[Bryn CPN interview: setting one: lines 66-95]

One aspect of examining rhetorical devices is to explore variability across versions as this can demonstrate the rhetorical orientation or action of the versions. Although I do not intend to examine this in detail here, it can be seen from the extract that Bryn's account was oriented toward powerful alternative accounts. His concern, with the disputed nature of his recall and admission to hospital, was countered by the CPN who constructed his recall as the result of 'threats to kill' [line 77] and the discovery of ammunition in his home [line 78]. The CPN also disputed his claims to lack of support by insisting that he preferred to do these things for himself and gains esteem from doing so. My intention in highlighting this variability is not to suggest that one version has more veracity than another. Rather it is to show that the function and structure of accounts are in part oriented toward competing or alternative versions. This orientation is demonstrated in attempts to achieve definitive claims of fact in the description of events. It may however also be the case that the nature of the events being recounted continues to have significant force in relation to identity claims of both professional and service-user participants. Professionals may seek to support identity claims related to their status as credible qualified workers who have a particular monopoly in decisions related to risk and mental health. Service-user participants as I have indicated in Chapter 4 address labels of deviance in their talk of arrest, conviction and admission to hospital. These labels are not easy to shake off

and may need active management in the talk of participants. One consequence of labels is that they may implicate different kinds of identity threats as conceptualised in notions of social sensitivity. I will return to this in Chapter 7 where I will show how the talk of people on conditional discharge was oriented towards identity-relevant aspects of social sensitivity and how this was handled in their accounts.

5.5 CONCLUSION

Aspects of the talk of people on conditional discharge have been examined here in micro-detail to show some common features of achieving identity work through the use of rhetorical devices. Although these examples are highly specific in their detail the accounts also show the more general everyday reality of people on conditional discharge. This may then suggest some lessons for those workers attempting to provide support and aftercare to people leaving hospital on conditional discharge which I will return to in Chapter 9.

The stories told by people on conditional discharge, and the workers providing aftercare, express a series of tensions experienced by participants. These tensions illustrate discontinuities between hospital and home or community time, as well as ongoing complaints and disagreements with those providing care. Everyday understandings of illness, professional caring and recovery are used as resources in constructing these accounts of discharge. Service-user participants in this study oriented towards notions of improved health and liberty over time as softening claims to the applicability of deviant labels. In some instances their talk can be read as narratives of resistance (Mishler, 2005), to more powerful professionals. In Chapter 7 I return to this aspect of narratives to explore how resistance narratives may help accomplish claims to ordinariness in the talk of people on conditional discharge.

Close analysis of stories also reveals that they function to do different types of situated identity work. That is, they are assembled to do different types of

identity work within the context in which they are told. One way in which they do this is by using common discursive repertoires such as atrocity stories. These establish moral boundaries and competence of speakers to provide credible authoritative accounts by using their experiences as a resource. This is achieved in consistent ways by speakers. These distinguish between the moral speaker and culpable others. In doing so, the accounts accomplish identity claims consistent with moves towards newer emerging versions of themselves as independent people. These are far from complete versions however and stories provided are as much oriented towards addressing competing accounts as they are towards establishing newer identities. The move to community living involves rehearsing these new versions of identity in talk.

In Chapter 6 I will explore the ongoing work in the talk of participants related to aftercare monitoring on conditional discharge. I will explore how service-users talk about the experience of living in the community and how aftercare arrangements are constructed in these accounts. I will show that for many participants there is continuing concern about the degree of control and monitoring that they are subject to under conditional discharge arrangements. One important aspect of community return is in establishing viable identities to enable community reintegration. To do so many people with enduring mental health problems have to address the twin challenges of stigma and discrimination. However some participants tell stories that suggest aftercare monitoring itself may be implicated in highlighting to the wider community those in need of ongoing supervision and monitoring.

CHAPTER 6: AFTERCARE MONITORING: THE UNEXPECTED EFFECTS OF FOLLOW-UP AND SUPERVISION

6.1 INTRODUCTION

In this chapter I present an analysis of the talk of participants related to aftercare monitoring, which forms an important part of conditional discharge. I explore how participants talk about the experience of living in the community and how aftercare arrangements are constructed in their accounts. I show that for many service-users there is continuing concern about the degree of control over their lives sanctioned by the use of Section 41 arrangements. Conditional discharge under Section 41 of the *Mental Health Act 1983* provides the legal means to return a person to hospital should discharge arrangements prove to be unsatisfactory, unsafe or if there is a deterioration in the individuals condition. Many respondents had experienced formal recall to hospital and others had returned informally to prevent formal procedures being instituted.

Although it struck me at first to be counter-intuitive, it was the case that for some participants their discharge to community living had resulted in increased supervision and monitoring. The notion of independence is one which is subtly subverted in the provision of aftercare services. This has been an important learning point for me in relation to the study of this field of practice. I had assumed that a move towards greater independence was suggested by movement from higher levels of secure care towards eventual community aftercare. That is, I understood community living to be synonymous with higher levels of independence or liberty from health services. However in some circumstances community living may actually lead to increased levels of direct care, monitoring and supervision. Participant responses in this study indicated that aftercare arrangements involve increasingly diverse means of monitoring and supervision. These function to

supply information on the progress and adjustment of the person. This information can be used to sanction and support a lessening of supervision and monitoring. It can also however be used to justify and warrant greater levels of supervision or the return of the individual to hospital.

Workers' talk is examined to show how readiness to wield the power of recall is cast as benevolent risk management. I will also show how workers are not immune to subtle undermining and categorisation of service-user accounts. This can be read as challenges to the identity work of service-users and an attempt to establish the ascendancy of professional accounts.

People who are conditionally-discharged from hospital are a heterogeneous group. Their views of aftercare expressed in research interviews for this study were however remarkably similar. Many service-users had long experience of over-stretched acute mental health services that were unable to meet their health and social care needs and they described the benefits that conditional discharge had brought them. These benefits included; regular visits from the care team, prompt responses when they were ill, access to funding to secure particular types of supported accommodation and the guarantee of an inpatient bed should they require a hospital admission. In times of limited resources and services struggling to meet the demands of community mental health care (Bindman et al, 2000), these benefits were seen as significant. Despite recognising and appreciating these benefits, concerns about the duration of continued monitoring was a feature of stories told in relation to time since leaving hospital.

Concerns have been expressed by service-users in other studies (Dell and Grounds 1995; Riordan et al, 2002) in relation to the continued scrutiny and surveillance that is a ubiquitous part of all forms of extended compulsory community treatment (Wells, 1998). These concerns include what is considered to be the intrusive nature of this type of aftercare. The concerns about intrusion suggest that the boundaries between the personal and public worlds of the individual are being transgressed in some way. The privacy of

the individual can itself be seen to be a dynamic process of negotiating the boundary between the individual and the external world. People who have been detained in forensic mental health hospitals are often challenged to allow access to intimate aspects of their personal worlds, for the purposes of assessments of their condition and their continued risk of dangerous behaviour. While detained in hospital, and with the carrot of a potential discharge, this may be an exchange that the individual will agree to. However once the person returns to the live in the community there appears to be increasing dissatisfaction with these arrangements.

It has been noted that prolonged forensic mental health inpatient care effectively socialises individuals to be more compliant with aftercare services (Dvoskin and Steadman, 1994). While detained in hospital, individuals are expected to make available for assessment their inner-most thoughts. Participants in the current study acknowledged that this was what was required to facilitate discharge. Continuing supervision and monitoring which is implied in aftercare arrangements however still require individuals to disclose private and personal aspects of their thoughts and behaviours to workers. Service-users are expected to comply with this focus of aftercare which in many ways mirrors their experiences of inpatient care. For instance, service-users were required to reveal intimate details of their emotional and sexual encounters with other adults to workers. They experienced these questions as intrusive and outside the remit of the professions but felt compelled to respond for fear that silence might be interpreted as evidence of hidden negative behaviours. I examine notions of privacy and disclosure in the talk of service-user participants in more detail in Chapter 7.

Time is an important yardstick of positive directionality in the narratives of the conditionally-discharged as I have shown in Chapter 5. The accounts offered by service-users indicate an expectation of lessening supervision and monitoring over time as a measure of improvements in their condition or perceived risk.

Workers in this study often categorised service-users as being 'open and honest' and this was constructed as a positive sign that the individual was compliant and therefore a good candidate for continued community supervision. Some workers described this element of their work as overly intrusive and report adopting strategies to deal with this, while others constructed their approaches as being justified on the basis of public protection.

The requirement of service-users to lay open their lives for inspection on a regular basis is perhaps evidence of the level of social control to which individuals are subjected. My analysis indicates that there were at least two forms of control employed by workers. These were firstly, pharmacological control in the form of medication to influence mood, thoughts and feelings and secondly, the threat of recall to hospital which enabled the imposition of a number of limits and controls on daily living. The use of pharmacological intervention was in almost all instances the primary mode of treatment for people who were conditionally-discharged and has been noted in other community studies of people with enduring mental health symptoms (Coffey et al, 2004). In the current study medication was reported as a significant and sometimes solitary treatment in accounts by both health and social care workers. Concerns about the use and abuse of psychiatric medications as coercive or punitive interventions were never raised by workers. Service-users however often mentioned the medication they received and although some were content with this, others raised concerns about how medication was used, the amount of medication they received and the effects of medication upon their lives.

As important as this area of investigation is I shall not explore it in detail here. My primary reason for this is that the focus of this study was on the accounts of service-users. Although medication was a significant concern in these accounts it appeared from my reading to be secondary to the concern about the continued threat of recall to hospital and the implications for sustained community tenure that such an outcome would have. The threat of recall

itself was often the rationale provided by participants for decisions to take the medication and as such can be read as a more fundamental concern.

The legislative power invoked by Section 41 restrictions ensures that limits on movement, travel, residence, community contacts and occupation can be controlled and if necessary prevented. The power to enforce these conditions is primarily associated with the threat of recall to hospital. Service-users for the most part felt compelled to agree to whatever conditions were proposed at the Mental Health Review Tribunal to enable their discharge. Once they had achieved discharge their perspectives of the conditions appeared to vary. Some saw the conditions as an inconvenient but necessary requirement and a better option than continued hospital detention. Others were more concerned about the continued power to recall them to hospital. Using extracts of both service-user and worker accounts I will present an analysis which will show some of the ways in which conditional discharge was talked about by participants. Based on this analysis I will argue that participants' stories constructed what can be seen as an effectively constituted transcarcerative model of extended and continuing control of the lives of people long after their discharge from hospital. It appears that locally negotiated cultural determinations of what Section 41 is held to mean may have significant power in the application of this form of control.

6.2 "IT'S LIKE CATCH-22": TRANSCARCERATION AND SOCIAL CONTROL

Conditional discharge under Section 41 of the *Mental Health Act 1983* is interpreted in practice as a warrant to enable workers to engage in a significant level of monitoring, scrutiny and control over the lives of individuals. During detention in hospital and through the process of seeking conditional discharge via a Mental Health Review Tribunal, a clear expectation is signalled to both service-users and workers that continued and ongoing monitoring is necessary for the protection of both the individual and others in the wider community. Throughout the course of this study in interviews with

both service-users and workers, repeated mention of aftercare and follow-up arrangements focused upon attempts to extend monitoring beyond the walls of the hospital and into the community. The professional literature on this aspect of forensic community mental health care is limited and focuses for the most part on overt evidence-based assertive interventions (Shepherd 1993; Coffey 2000b). This appears to avoid analysis of the relatively hidden elements of health and social care controls which form an important part of conditional discharge. Analysis of these controls is absent even where conditional discharge is itself the focus of study (Dell and Grounds, 1995; Riordan et al, 2002).

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 considered to be implicated in risk behaviours. Some respondents also reported being breathalysed to detect alcohol intoxication. Other forms of monitoring such as mental state assessment and risk assessment are conducted by interview at each meeting with workers, which often took place weekly. In many cases monitoring was 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 back to the clinical team on aspects of the persons' behaviour, sleep, mental state and daily living skills²⁸. For some participants, curfews were imposed to restrict movements outside of the placement during night-time hours. The requirements of monitoring 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 concerned one participant, Colum, as it "puts the employer off" [line 150] offering a job and effectively reduced opportunities to establish social inclusion through work.

What another participant, Brendan, referred to as "the big follow-up" [line 261]

²⁸ Direct sanctions were seldom available to professional workers if these agencies failed to provide the required information although it was suggested to me on more than one occasion that agencies who were considered as "excellent" in doing so were more likely to receive future business, in the form of referrals, than those who did not.

also included 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. Police, probation and prisons work together supported by other agencies such as Local Authority housing, Social Services, Health, and Youth Offending Teams to manage the risk dangerous offenders may pose to the public. Offenders can be managed at one of three levels. Level one involves a single agency, most commonly the Probation Service, without the need for other agencies to be involved in managing the individual's risk. Level two indicates that the risk management plan requires more than one agency. Some offenders posing the highest risks can be managed through referral at level two, where the plan is not complex and does not require commitment of resource at a senior level. Level three involves the "critical few", who are deemed to pose the highest risk of causing serious harm, and require multi-agency co-operation at a senior level. These critical few are referred to a Multi-Agency Public Protection Panel (MAPPP). As conditionally-discharged mentally disordered offenders many participants were subject to these arrangements and were aware of these meetings occurring as they frequently received visits at their places of residence from the police at these times.

Participants on conditional discharge had a sense then that they were someone who had "got to be kept an eye on" (service-user 3 interview 1: setting 1: line 299) by multiple community agencies charged with this task. The extent that people were actually routinely supervised by workers varied significantly depending on the type of accommodation they were living in, the length of time since discharge and the terms of their conditional discharge. For instance, those living in independent accommodation were seen by workers at most once or twice a week while two service-users in this study were required to be in the company of a housing support worker at all times. Professional workers from forensic services were however just one part of the net of supervision as I have suggested above. 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 persuasively summed up by one service-user who alluded to being like a puppet, “they’ll be getting some strings next and dangling me on strings” (SU8: Setting 2: line 438).

The extract presented below is taken from the second interview with Iestyn whom I gained access to in setting two. Iestyn was a man in his mid-thirties who had been conditionally-discharged two years previously to a twenty-four hour staffed supported housing placement. He had expressed a preference for short interviews but was keen to meet me on more than one occasion. Both research interviews were approximately thirty minutes long and took place two months apart. The second interview was conducted in his room at the supported placement where he had been living since his discharge some two years previously. This extract follows on from a turn where Iestyn had argued for legalising cannabis because its use was “very common now” among the general public. In this earlier turn he expressed a concern about the threat of being recalled to hospital if he should be found to be smoking cannabis. Taking his lead I enquired about monitoring by the clinical team of his drug use as this seemed to me to be indicative of the level of surveillance that was increasingly part of aftercare.

- 30 MC: It seems people might be more worried about cannabis or about drugs more
31 generally, are you having urine tests?
32 R: I do yeah.
33 MC: How often does that happen then?
34 R: It’s whenever they want to. They can give you a urine test here I’m talking about
35 now anytime they want to.
36 MC: And that has happened before?
37 R: I’ve had urine tests yeah.
38 MC: And how has that been?
39 R: Umm, (2) they found out that I was smoking cannabis. I had to stop smoking it
40 because if I hadn’t, I went into hospital voluntary just before Christmas for two
41 weeks, (2) they called it a respite but supposedly something about if I hadn’t gone in
42 voluntary there was a possibility that I might’ve got recalled. If you’re recalled that
43 means you are readmitted into hospital, they don’t have to put a section on you, all
44 they got to do is put a 37 in front of my 41, cause the 37 is the hospital part and I
45 would have to stay there and have a tribunal to get out. I’d be in there minimum a
46 year, could be anything more than a year, could be a year and a half because they’re

47 going to say he's going to go back out and smoke it again or something. It's like
48 catch-22 and as I was saying it's not a hard drug, there's a lot of people who, some
49 people who smoke a lot of it they smoke it all the time you know and they become
50 addicted to it in a way because it's like (3) you get used to it, it becomes part of life
51 smoking that.

[lestyn second interview: setting 2: lines 30-51]

In lines 34-35 lestyn explained that urine tests to detect cannabis smoking can be conducted "anytime they want to". The threat of these random spot checks had led him to stop smoking cannabis when he had been found to be using it. The outcome of this discovery had been a voluntary hospital admission which he had felt compelled to agree to under threat of being formally recalled [lines 40-42]. Agreeing to an informal admission, however unwelcome, was likely to result in a much shorter stay in hospital than formal recall. lestyn outlined the implications of recall in that it would result in detention in hospital for a significant length of time, "I'd be in there minimum a year" [lines 45-46]. His account demonstrated a common understanding held by both service-users and worker participants of how recall works and the likely outcomes for the individual.

lestyn's account provided the perspective of someone who was subject to a number of levels of overt social control, exercised through reliance on the dominance of medical knowledge. This knowledge is based on findings that ingestion of cannabis heightens risk of psychosis (Arendt et al, 2005). Substance abuse more generally has been shown to be associated with increased dangerous behaviours exhibited by people both with and without mental illness (Steadman et al, 1998). This knowledge increasingly informs the risk assessment and management practise of mental health and social care workers providing aftercare services (Webster et al, 2002; Doyle and Dolan, 2007). It is likely that this knowledge would have been communicated to lestyn by workers in an attempt to educate (socialise) and provide a rationale for establishing compliance with aftercare arrangements. lestyn indicated that he was effectively helpless in the face of the likely sanction that was available should he resist or fail to comply with requests to stop using cannabis. His attempts to assert that cannabis use is normative practice can

be read as an appeal to more liberal understandings of recreational drug use. This was an attempt to make his claims reasonable and by doing so garner sympathy from the listener. The account functioned to establish cannabis use as normative and allows the construction of the clinical team's responses as unreasonable. Cannabis smoking was to be seen as part of his life and the implication was that it was to be seen as a loss of one part of how he wished to be known.

lestyn's story also had the qualities of an oppressed discourse. The attempt to solicit sympathy may be one feature of this. His talk contained repeated reference to the faceless "they" who wield power to which he had little response. There was a sense of the pervasive all-seeing, all-knowing authority which was always ready to step in and remove freedoms. lestyn's account can be heard as expressing concern about this omnipresent omniscient total state. lestyn explained that if recalled he may be prevented from leaving hospital because workers will infer that he was likely to return to smoking cannabis again [lines 46-47]. lestyn's account functioned to access everyday understandings with his reference to "catch-22" as he sought to press home his claim. Catch-22 refers to inherently illogical rules or conditions which prevent a satisfactory outcome to a given situation. This communicated to the listener that the situation the speaker found himself in had no obvious agreeable exit route.

lestyn's reference to "catch-22" can also be read as an idiomatic expression (Drew and Holt, 1988) in that it was aimed at clinching withheld support for a complaint about living under what was constructed as unreasonable conditions of discharge. The allusion to "catch-22" appeared in other accounts provided by service-users in this study and in each case it was aimed at securing support for complaints about the nature and intensity of aftercare monitoring. Conditional discharge as a form of total social control is a perhaps a facile allusion, however lestyn was providing the account from the inside. His account worked to construct the constant threat that his behaviours were being monitored and that negative assessment of these

would result in a loss of liberty. The total state was presented as being very real to him and to others subject to conditional discharge, even if there are arguable limits to such an analysis.

One way in which analyses of social control can be limited is in terms of seeing institutions or the state as unreceptive to reform. In such a view the state via its institutions can be seen to be

“invulnerable, immutable and impervious to the efforts of human agency and intention”

(Lowman et al, 1987a: 6).

The accounts of service-user participants indicated that this was how the powers of recall to hospital were experienced when individuals resisted some of the conditions of their discharge²⁹. Workers however constructed alternative versions of conditional discharge in relation to continued monitoring and supervision. Their accounts indicated that concerns about risk and public protection weighed heavily in decisions about continued aftercare and relaxation of conditions. As such the imperative to reduce or manage risk behaviours was fundamental to their work and the conditional discharge order was seen as a useful means to this end. This may be particularly so as, with exception of prescription of medication, workers have limited options in managing the uncertainties of another's behaviour.

Iestyn's concern with recall was mirrored in the talk of the CPN who was clearly oriented towards exercising the authority that conditional discharge allowed workers. The following extract is taken from a research interview conducted in the clinical team offices in setting two approximately three weeks after my second meeting with Iestyn. The CPN had been working in community mental health services for many years and had known and worked with Iestyn intermittently for approximately ten years. His demeanour towards

²⁹ Service-user participants who reported no concerns or resistance to the conditions of their discharge tended to construct aftercare as a form of benevolent surveillance aimed at ensuring they remained well and had continued access to treatment.

lestyn was less than sympathetic and I discerned a certain irritation directed towards lestyn's lifestyle choices.

231 MC: Has the restriction order been helpful or unhelpful in helping him to resettle in
232 the community?

233 R: I think you know somebody like [lestyn] it is helpful with his history like you
234 know I mean umm (4) personally I think you know if he wasn't on an order or
235 conditional discharge he would not come for clozaril bloods to be honest with you, he
236 would come off the drugs and go on the drugs he prefers to be on, (1) you know.

237 MC: So for him it has been generally helpful to have

238 R: I think I mean you know it does help in the long run like for instance umm like
239 having to recall him it was one of the things that helps us and the 117 meetings have
240 been helpful as well. (2) The 117 meeting you know that we hold for him as well I
241 mean obviously if he wasn't under a section you know he wouldn't have been subject
242 to that anyway.

243 MC: So that gives him [another sort of

244 R: Yeah well] support in a way but on the other hand you think you know it is still
245 keeping an eye on him too and his welfare and you know so it works both ways really.
246 (12) You find some time with people lacking complying with this umm medication
247 you just say look you are on section 41 you have got to (3) to do this that and the
248 other and then they do it, otherwise they wouldn't do it [little laugh].

[lestyn CPN interview: setting 2: lines 231-248]

The CPN indicated in his account that lestyn's perception of the threat of recall from workers was very real. In the intervening weeks, between meeting lestyn for the second time and securing the interview with the CPN, lestyn had indeed been recalled. The CPN's talk can be read as indicating that lestyn could be seen as a particular category of person. The presence of a category was established, in response to a question about the helpfulness or otherwise of restriction orders in resettling people in the community, when the CPN opened his response with the phrase "somebody like [lestyn]" [line 233].

The cue that a categorisation was being used was then supported in the following lines with an explanation that lestyn was to be seen as unreliable. Without the restriction order the CPN argued that lestyn "would not come for clozaril bloods" [line 235]. This was to be understood as a particularly dangerous type of unreliability³⁰. The anti-psychotic clozaril had been

³⁰ This account appeared to be accessing shared professional knowledge about psychiatric medications and the associated management of them. The speaker does not explain what he means by clozaril bloods nor why they are considered to be so important. Assumptions that shared knowledge exists between the speaker and the researcher appear to be active

reintroduced for the treatment of people with schizophrenia following withdrawal from the market in the early 1970's when it was implicated in a number of fatal incidents. One effect of clozaril is that it can cause sudden and ultimately fatal decreases in white blood cell counts leaving the recipient vulnerable to severe infection (Krupp and Barnes, 1992). The requirement to attend for monitoring blood tests is a condition of taking the medication and was an important element in securing a new licence for its use. Failure to attend for these blood tests was then to be seen as being tantamount to a type of recklessness of "somebody like [lestyn]".

The CPN's account indicated that power of recall was "one of the things that helps us" [line 239]. The phrasing used highlighted that it was not just the speaker who was helped, but rather the collective "us". This collective does not include lestyn, but refers to the clinical team who were being helped in providing aftercare to him. The use of the collective "us" worked to add weight and support to the claims of the value of using the powers available. Put another way, the powers available to workers in the form of conditions placed on discharge, are not to be seen as simply for the convenience of this speaker but are supported as beneficial by the wider clinical team. This phrasing also indirectly acknowledges that powers of recall are not at the behest of the CPN. These can only be directly wielded by other professions in the clinical team although CPNs have claimed a degree of influence over their use (Coffey and Jenkins, 2002).

The CPN's account can be read as rhetorically organised to address competing accounts such as those provided by the service-user participant. The requirement to hold Section 117 meetings was offered as another means to keep "an eye on him and his welfare" [line 245]. So this was constructed as an altruistic goal of aftercare and not simply to limit and restrict his behaviours. The categorisation "somebody like [lestyn]" [line 233] can be read as functioning to undermine previously provided versions of events. As such this account showed awareness of competing accounts, such as lestyn's, that challenge or resist the range of social control powers employed

by workers in maintaining conditional discharge. This account appeared to be the product of the institutional regimes that occasioned talk related to aftercare monitoring.

In producing this account the CPN was reflexively aware of what was being said and managed this to portray a particular version of how conditional discharge orders work. In the opening lines the version offered was that unreliable people need to be helped, and the restriction order helps the helpers to ensure that people get this assistance. This version however was open to a critical reading or at the very least alternative competing accounts either directly in the interview interaction or from a secondary source such as lestin himself. Closer examination of this extract shows that the speaker changed tack after this initial version to present the benefits of the conditional discharge order. These were benefits for the individual in the form of Section 117 meetings. Section 117 meetings are statutory discharge planning and review meetings required under the *Mental Health Act 1983* and require the clinical team to meet with the person and their carers to review progress and make alterations to treatment plans. In lines 239-240 the speaker explained that these meetings “are helpful as well”, in addition to recalling the person to hospital. So we are to see that aftercare was not just about the power of recall. The speaker followed this by emphasising that the meetings “we hold for him” were to be seen as benefiting the individual. The emphasis was placed here so that the benefits were to be seen “for him” rather than for the team directly.

The speaker, in referring to Section 117 meetings, holds that “obviously if he wasn’t under a section you know he wouldn’t have been subject to that anyway” [lines 241-242] indicating perhaps that although benefiting from this arrangement the individual was also seen as “subject” to these. Nevertheless line 240 in this extract can be seen to be a turning point in which the speaker began to outline some of the positive elements of conditional discharge which lestin had benefited from. In doing so he revealed the tactical nature of this account which initially offered a more coercive view of the conditional discharge order and then moved to balance this with benefits of Section 117

meetings and being kept “an eye on” for his “welfare” [line 245]. As if to highlight and conclude this shift of emphasis the speaker indicated that “it works both ways really” [line 245]. This reads as a tactical balancing of dominant professional ideologies of control with the intention to offer care (Mason and Mercer, 1996), and the production of an acceptable account for the purposes at hand. This was ultimately unconvincing as after a long pause the speaker indicated that he was oriented to using the order to insist that service-users comply with treatment conditions. Initial analysis suggests that lestyn’s concerns about constant monitoring and the likely negative effects were realised in the CPN account in which a readiness to use the implicit threat of recall was clearly evident.

Workers’ accounts focused upon what might be regarded as risk management and risk reduction tasks associated with aftercare services. The need to assess, manage and reduce risk behaviours by people discharged from hospital was the central focus in many worker accounts and is reflected in the wider literature on community aftercare services of forensic teams (Mohan et al, 2004). This was often framed as a form of benevolent intrusion upon the private lives of service-users. The restriction order enabled workers to compel lestyn to take prescribed medication as without it he would “come off the drugs and go on the drugs he prefers to be on” [line 236]. There was a twofold implication that, firstly the drugs lestyn “prefers to be on” were illegal substances and as such this was evidence of his lack of rationality. Prescribed medication we are to understand keeps lestyn safe from dangerous risk behaviours whereas the use of cannabis may increase this risk. Worker accounts provided in this way accomplish more than claims of unreliability or lack of rationality however, they also imply particular occupational identity orientations and challenge identity claims assembled by service-users. Challenges evident in the talk of workers may actually work to undermine service-user attempts at establishing new identities.

To a certain degree the performances of workers in research interviews for this study were measured, careful and perhaps even tactical³¹. However this may be difficult to maintain over the course of a long interview and invariably less formal versions of how they viewed the behaviours of some service-users were revealed. In many instances these involved negative evaluations, moral declarations and direct challenges to the inchoate identity work of service-user participants.

This undermining of new identity claims may be subtle and it is not clear if these challenges appear in talk between service-users and workers in day-to-day interaction. I do not imply that they are specific to circumstances involving conditional discharge. Undermining of identity claims may be a feature of the talk of mental health workers more generally. It has been noted that mental health workers' attitudes towards the mentally ill are less favourable and more pessimistic than the general public (Hugo, 2001). I can only speculate as to the likely effects of such covert lack of support upon emerging identity work of people newly returned to community living following prolonged hospital detention. Service-users certainly did not directly refer to this, although those who were unhappy with the continued level of monitoring and supervision appeared to me to be articulating the difficulties of establishing newer identities, in the face of challenges presented by continued contact with workers among others.

Continued supervision in the form of aftercare was described by service-users as like "living under a microscope" [SU10: setting two: lines 509-510], and "more intrusive and restrictive than ever before" [SU14: Setting two: line 32]. Across the sample of participants there was a clear trend towards greater dissatisfaction, and concern with the continued nature of aftercare monitoring, among those who had been discharged the longest. In many ways these participants had more to lose by the threat of recall to hospital. Perhaps too

³¹ As I have noted earlier there was a certain reluctance to participate in the study expressed by some workers who perhaps wished to maintain the hidden nature of their work. This never materialised as outright refusal but some workers continually failed appointments, claimed their diaries were full when there was no entries at all on the pages they were referring to, or indeed were highly suspicious of my motives for wishing to investigate service-user perspectives of conditional discharge.

they had less need of the ease of access to treatment and inpatient care that appeared to be an important feature of talk that stressed the benefits of conditional discharge.

As I have indicated, the provision of aftercare visits by workers was seen by many participants as initially helpful if overly intrusive at times. Aftercare can include multiple visits by individuals, or groups, of workers for the purposes of administering treatments such as medication or relapse prevention, providing help with basic living skills such as shopping and budgeting, or even escort and transport to day-care services. One unforeseen outcome of this level of support and aftercare however is the potential it offers to single out and identify individuals to the communities in which they reside. In the next section I move on to analyse talk which directly implicates workers in contributing towards the community rejection of the mentally ill.

6.3 “PEOPLE... WITH BRIEF CASES AND DOCTORS AND NURSES AND ALL THAT SORT OF THING, IT LOOKS A BIT FUNNY”: AFTERCARE MONITORING AND DEVIANT STATUS

For many people the return to community living raises significant challenges to achieving successful social bonding and adjustment. An important hurdle is the attitude of the general public to people with mental illness. Large scale surveys of attitudes to the mentally ill among the general public have found that the vast majority (80%) were embarrassed by the mentally ill (Huxley, 1993). It was also noted that this finding was no different to an identical study 10 years earlier (Huxley 1993) demonstrating that attitudes are resistant to change and may be so embedded as to require significant longitudinal public education programmes.

Negative attitudes towards the mentally ill can lead to experiences of discrimination and social isolation for people living with these conditions. These experiences have been reported in surveys to include being dismissed or forced to resign from jobs, being abused or harassed in public, being physically attacked, refused insurance or finance and being treated unfairly by general health care services (Read and Baker, 1996). Opposition to the placing of community mental health facilities has also been noted (Repper et al, 1997). These findings have led to concerns about the impact of negative attitudes upon mental health, recovery, quality of life and social adjustment of people diagnosed with mental illness (Perlick, 2001). For instance, in the United States it has been found that fears about stigma held by people with mental illness during the acute phase of their condition were associated with significantly poorer social adjustment on discharge (Perlick et al, 2001). This poorer social adjustment was specific to social interaction with people outside the family indicating the locus of the problem leads to increased social withdrawal. Families themselves perceive more negative attitudes to mental illness than national surveys suggest (Struening et al, 2001) and report concealing the illness and hospitalisation from associates (Phelan et al, 1998). This is perhaps one explanation for the finding that people discharged from forensic facilities reported feeling a sense of belonging in their own homes while remaining poorly integrated into the communities where they lived (Gerber et al, 2003).

Diagnosis and treatment for mental illness therefore has significant negative potential for discrimination and social exclusion. People who have forensic mental health histories have the added burden of a criminal conviction. In many instances service-user participants were returning to the very communities in which their offence occurred. In some cases these offences had received high profile media attention locally, if not nationally, which raised the possibility that they may be more readily identified within their own neighbourhoods. Participants reported adopting strategies to avoid any further negative public attention once discharged. These included changing their names, avoiding public places, glossing over their offences in

conversation or concealing their enforced absence. In some cases this latter strategy involved telling people they had been working away from home for a few years. When social situations demanded that accounts of the offending behaviour were required, participants reported strategies such as altering details of events to present versions deemed less socially deviant. I will present an analysis of the functional nature of these accounts in Chapter 7: however its relevance here is to highlight the identity-relevant negative associations which mental illness and criminal offending imply for actors in social situations. 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 as helping 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 and MAPPP intervention in the form of repeated visits from the police.

The extract presented below is taken from an interview (lasting just over one and half hours) with Bill who I gained access to in research setting two. Bill was a man in his forties who had been in contact with mental health services for most of his adult life. He had been recalled to hospital a number of times due to concerns about his risk behaviour in the community. The interview took place in his room in a recently opened and newly renovated supported house where Bill had been living for 5 months since his conditional discharge. Bill's delivery was slow and at times his speech was slurred which I took to be the effects of the medication he was taking. He was aware of this himself and made reference to it a number of times during the interview. His concern about this was framed as one of side-effects causing him to stand out in a crowd and making him appear to others as someone with a mental illness. Bill's discharge had involved a number of attempts to secure suitable supported accommodation and seeking his agreement to relinquish his flat where he had been living independently prior to his admission. In this extract from early in the interview he responded to the prompt to talk about leaving hospital and told a story about his wait to leave hospital and eventually moving to his new home. Within the context of his discharge from hospital he

indicated his perception of problems associated with visits of workers to his home.

- 50 MC: I'm interested umm first of all umm about you leaving hospital on this occasion
51 and umm coming to live here. Maybe you could start with when you knew you first
52 knew you were going to be leaving.
- 53 R: Well I heard six months prior to being discharged, conditionally-discharged they
54 were talking about coming here but prior to that there's another place called [place
55 name] out in [distant county] somewhere I think it was by (2) [place name]
56 somewhere like that but they turned me down. They weren't taking the right kind of
57 client in (2) umm so then after that I was told about this place (2) and umm I was well
58 in hospital for six or seven months or so just waiting to come here. It was quite
59 distressing it was. (2) When I say well I mean I still get I get intrusive thoughts and
60 things like that but that's not the mainstay of my illness (10) finally I got here. I was
61 one of the first to arrive and view the place see and everything like but I'm sure how
62 quite how long it was but now I'm here and it seems great. I was living in my own
63 flat not far from the hospital. I'd been there about umm seven or eight years I think it
64 was. But things got too difficult for me there. (2) My neighbours around me, well
65 they died actually either side of me both elderly people I was very friendly with them.
66 Since they went the other neighbours I didn't really get on with (2) for some reason.
67 (2) They may, see when you've been discharged from hospital on a 117 you get
68 people coming to your house with briefcases and doctors and nurses and all that sort
69 of thing it looks a bit funny you know (4) it doesn't matter here so much (17)
- 70 MC: So you [think
- 71 R: Very stigmatising] it is you know (5) I'm not I don't get I'm not feeling too bad
72 when I'm out here but umm I'm more accepted being out here I think than on the
73 estate where I was before (23) I don't know what else to say really other than most of
74 the problems I have are kind of intrusive thoughts horrible thoughts awful sorts of
75 things like that and umm I've never done anything awful but I think awful things (1)
76 and I think intuitive people tend to pick up on it. It just ruins my life you know (3)
- [Bill interview: Setting 2: lines 50-76]

Bill's account in these opening lines can be read as one in which he plays a passive role. He framed this as being told that others were preparing for his conditional discharge, for instance "they were talking about another place" [lines 53-54] and "I was told about this place" [line 57]. This may be indicative of prolonged hospitalisation in which individuals incrementally devolve responsibilities for everyday aspects of their lives to workers. Social psychologists have suggested, that for people who have debilitating health conditions, a state of what is referred to as learned helplessness ensues (Walker, 2001). Learned helplessness is a belief in a total lack of personal control over a situation. Although the concept has central importance in

health self-management initiatives (Mueser et al, 2002), it appears to have some overlap with observed behaviours of those institutionalised for long periods in that individuals have learned that their efforts to assert themselves don't work and henceforth fail to make renewed attempts to self-care.

Bill's account also had the features of a complaint which appeared to be based upon common everyday understandings of illness and recovery. He was well but needed to remain in hospital while accommodation was sought and this was "distressing" [line 59]. Bill accessed common expectations that once a person is well they should leave hospital. His account also raised the possibility of a challenge to his current living arrangements in a supported placement. Bill appeared to be aware of competing versions which question the need for supported placements for people who are now considered well. In this instance his account functioned to address these competing accounts. This was achieved by following his claim of the distressing nature of remaining in hospital when he had already recovered, with a further claim of enduring symptoms.

Bill followed this account by positioning his previous living situation as a contrast to his current placement. This functioned to provide an additional explanation of why he was now in supported accommodation, rather than living independently. Living independently is commonly understood to be a more desirable state and a measure of achieving recovery and freedom from the scrutiny of mental health services in the accounts of service-user respondents in this study³². Bill explained [line 63] that he had been living in his own flat for "seven or eight years" which can be read as signifying persistence. He had not chosen lightly to relinquish his flat and this decision was constructed as being the result of problems with his neighbours, "but things got too difficult for me there" [line 64]. This implicates causes external to the speaker as being responsible for the problems encountered in

³² In all cases where service-user participants were living in supported accommodation there was explicit reference in their accounts to moving on and achieving independent living in a flat or house of their own. This can be read as identity-relevant talk in the stories of conditional discharge and appears to be taken as emblematic of positive directionality or in other words evidence of movement towards improvement and recovery.

maintaining independent living. Bill's talk was structured to present the problem of not getting on with his neighbours, and then provided an explanation for this in this form of visits from workers. Both the externalising of the problem and provision of a ready explanation had significant rhetorical power, making the account both plausible and convincing.

Bill's talk about problems with his neighbours made use of commonly available knowledge about people with mental illness and the likely negative effects of their illness-related behaviours. His account accessed information about societal responses to the mentally ill as evidenced in reduced opportunities for social integration. To a certain extent the talk here externalised the reason for being identified by his neighbours. From Bill's account it was not his demeanour, his behaviours or his symptoms that identified him as mentally ill but rather what he saw as the stigmatising effect of workers visiting him at home. Bill explained his difficulties with social relations as resulting from the death of his elderly neighbours whom he was "very friendly with" [line 65]. So his problem was not to be seen as generalised to all neighbours, but with the more recently arrived neighbours. This was also constructed as a problem related to how he was seen by these neighbours. The frequent visits by workers and statutory services in-effect unmasked him to the local population. He described these visits as looking "a bit funny", that is they caused him a certain amount of social embarrassment.

Bill suggested that visits by professionals highlighted to the community around him that he was someone who needed supervision. Bill's account also suggests 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 (as identified by their briefcases), must be in need of special supervision, care and monitoring and are therefore liable to be categorised as someone to be cautious about. Bill's talk can be heard as an attempt to access this culturally available knowledge as a way of explaining his difficulties in establishing social bonds with people in his community.

Concerns about stigma and discrimination in mental illness have focused upon presentation of self and the subsequent labelling behaviours of actors within social systems (Lemert 1962; Goffman, 1963; Scheff, 1966/84; Link et al, 1989). Evidence of the detrimental effects of stigma and discrimination have led to the issuing of central guidance and policy directing mental health services to put in place evidence-based practices to address this problem (Department of Health 1999, Welsh Assembly Government 2005). One such response is the provision of assertive outreach type services where the emphasis is on provision of services in the community where the person lives. Statutory aftercare provision in forensic mental health services have in many cases adopted this model as a way of ensuring the delivery of aftercare services to a population where risk behaviours are believed to increase in the presence of untreated or unmonitored mental illness (Kelly et al, 2002; Judge et al, 2004).

Bill suggested in his account however that statutory aftercare services may actually contribute to stigma in the process of providing support and supervision. Concerns about negative labelling from communities may lead the individual to withdraw and disengage from others in social systems. This can be a problem for the individual if we accept that engagement is itself a positive and contributory part of securing social capital. It can also raise problems for the society too in that social capital is seen as an effective means to social control (Portes, 1998). However as Portes (1998:5) has indicated, the presence of social capital is not sufficient of itself to enable individuals to benefit from it, they must also have the ability to obtain it by virtue of membership of different social structures. Exclusion from social structures in the form of withdrawal and disengagement may therefore jeopardise opportunities to benefit from available social capital, reducing the possibility of social control and jeopardising community tenure (Kelly, 2005). My analysis of participants' talk suggests that arrangements for monitoring and scrutiny of people on conditional discharge may lessen the need for social control obtained through access to social capital. Direct powers to access the

person for assessment, intervene in social interaction in the form of limiting specific social contacts, compel treatment and if necessary return the person to hospital, offers workers and service-users alike clear social control imperatives. However, this is a short term measure that may not be sufficient to support continued community tenure once the order is eventually terminated. In such circumstances, the development of opportunities to benefit from social bonding, adjustment and integration may make community tenure more sustainable. Workers however placed much less emphasis on this as part of their work. Instead issues of public protection, risk assessment and establishing alternative and extended forms of monitoring were foregrounded in their accounts.

Bill framed the experience of visits by workers as being one which “looks a bit funny” [line 69]. This was especially so when he was living independently in his own flat. Within that social setting visits by workers may indeed appear outside the usual course of events. In effect such visits provide opportunities to be seen as different from others in the same setting, who don’t have such visits, or indeed to be categorised with those who do. This can lead to problems in managing identities within those communities. Bill indicated that this problem did not exist in the current setting to the same extent [line 69]. In doing so he positioned independent living within the wider community as being qualitatively different to supported living within a staffed placement in terms of the available assignable labels. Bill indicated that he was “more accepted out here” compared with his former accommodation. It is not immediately evident why this should be the case, although the structure of the account appears to require a positive spin on his decision to give up independent living in exchange for supported accommodation.

Bill’s account can be read as one which highlighted the identity challenges that are part of living with mental illness in modern society. While attempting to live independently Bill has had to sustain his identity as a competent adult capable of managing his own home, a view which was constantly challenged by his repeated hospitalisations and the requirement for visits by statutory

services. His account demonstrated that he was keenly aware of the negative identity labels available, and assignable, to social behaviours that can be categorised as mental illness. In other parts of this interview for example he explained, how his arrest in a public place was “quite embarrassing” [line 116], his concern about medication side effects “makes you stand out a bit” to the wider community [line 78] and how visits from the police “alienated me from my neighbours” [line 141]. This can be read as awareness in his talk of the socially sensitive nature of identity performance, both within the interview, and of events retold. Bill’s account functioned to imply that deviant labels of mental illness were ones he would wish to avoid because of negative identity orientations and securing social bonding. The difficulties of integration were cast as emanating from the failure of others to accept him as a result of his contact with mental health and social care services. This can be seen in this extract [line 73] where after a long pause Bill constructed his “problems” as being related to unwanted mental distress which had “ruined my life” [line 76].

These final lines of the extract [line 75] included the seemingly throwaway phrase, “I’ve never done anything awful”. This phrase functioned to create distance between claims that a criminal deviance label was warranted, and enabled Bill to accomplish in the final lines of this turn a particular gloss on events that will be later told in more detail. Bill’s account accomplished the task of foregrounding mental illness explanations for his current living arrangements and for conditional discharge and aftercare. In doing so, Bill achieved an identity orientation through his talk which indicated that despite negative outcomes of deviant labels of illness, he was still prepared to use these as explanatory devices for untoward behaviours, such as those which led to his arrest and conviction.

There is a careful balancing act to be achieved in accounts which lay claim to mental illness and or criminal offending identities. Mental illness is a health condition commonly associated with unpredictability and dangerousness (Pfohl, 1978; Litwack, 1996). Media representations of mental illness frequently highlight these negative orientations while eschewing more positive

reports (Berlin and Malin, 1991; Huang and Priebe, 2003). Communities are likely to be influenced by such reporting particularly when the focus is invariably on dangerous acts (Cutcliffe and Hannigan, 2001). One response is the emphasis placed on mental health services to focus on risk assessment and management of violent behaviours (Department of Health 2002; Doyle and Dolan, 2007). Despite this focus it is well recognised by proponents of risk assessment techniques that accurate prediction of future behaviours has remained limited (Monohan, 1992; Litwack, 2002; Webster et al, 2002).

In terms of available deviant labels there is perhaps a subtle distinction between asserting mental illness labels over criminal offending ones. Both are particularly sticky labels it seems and there is arguably little to choose in terms of public reaction to either one of these. Illness claims may work in accounts, as we have seen, to warrant absences from expected responsibilities. They may also access common understandings of illness being linked with recovery and hence the possibility of resolution and role exit. This appears to be the preferred label where the mental illness condition is severe and enduring and where discharge from hospital is a recent occurrence. Criminal offending labels are used in talk of service participants to resist ongoing and perhaps intrusive monitoring by aftercare teams. They may not be used in other circumstances however because, while illness may get better it is less clear that the bad can become good. Any claim deployed by service-users however is always open to challenge, modification and even rejection. In social settings, service-users may deploy identities in talk as a means to reduce opportunities for direct confrontation that might arise in the form of competing versions.

6.4 “THESE TYPE OF PEOPLE”: CATEGORISING TO UNDERMINE

One source of competing claims is from the workers providing support and aftercare monitoring. The following extract is taken from an interview (lasting about 45 minutes) held in the clinical team offices in setting two with the CPN

responsible for visiting Bill in the community. The CPN had known Bill for a number of years both during his detention and his previous discharges. During the interview he portrayed his relationship with Bill as being warm and friendly which was in direct contrast to Bill's talk about this very same relationship. The CPN's account constructed much of Bill's concerns as a heightened awareness of the realities of community living in which mental illness was implicated. In doing so the account also functioned to undermine Bill's claims with reference to his mental ill-health.

86 MC: Given his history and given what was probably likely to have been a quite public
87 incident how has he managed to reintegrate, he did allude to people where he had his
88 flat being quite cautious about him and anxious about him returning.
89 R: (4) He doesn't talk about the people in the area where he is now being aware of his
90 notoriety as he puts it umm as I say he will think that things are going on much more
91 intensely than they really are but he's umm he has it in his head that you know
92 yesterdays news is tomorrows chip paper and that's all it is because people don't hold
93 these things in their heads about what happened in the past they won't remember him
94 certainly won't remember what he looks like unless they had direct involvement.
95 Umm and he seems more relaxed about it. The only problems they have had in the
96 area from people in that area is from young children kicked their ball over the back
97 wall and they had a bit of nonsense from that. It wasn't umm (2) it wasn't as bad as it
98 could be but certainly where he was living in the past because where he was living in
99 the past was a flat in a block of flats umm, open access to front and back umm, on the
300 ground floor umm, he had delusionary ideas about people above him, people on the
301 left and the right of him and there were others in the block who had mental health
302 issues as well. We know this because we visited several of those people as well so
303 you have a group of people who had mental health issues in one block in one area and
304 the local population would tend to shun them there's no doubt about that. So these
305 ideas that he is being shunned or being pointed out or being talked about (2) are
306 probably emphasising reality going on as well. It's always very difficult to stop
307 people being (1) stigmatising towards people with mental health issues (2) so where
308 he is now (4) I think they've accepted them in the area. There was a public meeting
309 about who goes in there umm fortunately or unfortunately I don't know which way it
310 depends who you are I suppose but one of the people who live in the area is one of our
311 colleagues. So they live by the building umm and they were able to say to people in
312 the meeting that you know how much care would be given and how much support is
313 there and how much is available for them and the full impact it probably would have
314 on people in the area and they were willing to wait and see and I don't think there's
315 been a huge impact on the area because they aren't seeing (2) people with mental
316 illnesses running around the place with no- uh nobody saying or doing anything to
317 them. Well they're just not doing that anyway, most of these type of people they
318 don't make a lot of noise they don't bring attention to themselves [laughs].

[Bill's CPN: Setting 2: lines 286-318]

Mental health workers themselves are not immune to holding negative attitudes about people with mental illness (Hugo, 2001) and indeed there persists a therapeutic gloom in respect of many interactions with people with enduring and serious forms of mental ill-health (Murray and Steffen, 1999; Markham, 2003) and which are seen by service-users as hampering their recoveries (Deegan, 1988). The CPN's account can be read as accessing some commonly held views of the mentally ill. For instance, Hayward and Bright (1997) have suggested a number of possible reasons for negative public reactions to people with mental illness. These include fears about dangerousness and unpredictability, attribution of responsibility (individuals are responsible for their conditions and choose to behave as they do), a belief that the condition has a poor prognosis which appears to be correlated with greater social rejection and a belief that the mentally ill do not fit into normal patterns of social interaction.

In this extract the CPN's talk functioned to undermine previously provided accounts by Bill. I will show here how this ultimately accomplished the task of creating doubt and uncertainty about Bill's claims. This functioned to achieve a categorisation of Bill as belonging to a certain grouping of people.

This extract opens with a prompt based upon Bill's concerns of problems related to community responses to his condition. At first the CPN indicated that these were not concerns that were current or even persistent [lines 289-297]. However the speaker then switched tack to indicate that if concerns were present then they were most likely the result of the pathological process of Bill's illness. A complete denial of an already accessed account is difficult to sustain. The resort to psychiatric pathology can be seen as accessing a ready-made resource which both speaker and listener can access by virtue of shared professional backgrounds. These are artful utterances designed to convince and persuade. The CPN constructed the problems with neighbours as being partly the result of "delusionary ideas" [line 300]. This claim was built upon incrementally over the course of the account and had the effect of confirming what was then labelled as delusionary. This enabled the speaker

to initiate and then install the category, “these type of people” [line 317]. For this category to be achieved it was first necessary to outline in talk some of the constituent elements of what was to be known as the category.

The category “these type of people” which includes those with “delusionary ideas” did not simply appear in the talk of the speaker. It was achieved by careful placing of cues to indicate that a category was present and attributable. Antaki et al, (1996) have noted that identities are *used* in talk, they never just appear. The CPN was seeking to establish an identity category for Bill which would work as the dominant one by which he was to be known. The development of the category was signalled at the very beginning of the CPN’s response in this extract, with allusions to the unreliability of Bill’s claims. The CPN wanted it to be known that “he [Bill] will think that things are going on” [line 290] and [line 291] that “he has it in his head” that people don’t hold information about events for very long. At this early stage of the response we are to understand that Bill was someone who held unfounded beliefs about events external to him and that these were firmly located in his head rather than elsewhere. Concerns about public reactions to Bill as someone with a mental illness were dismissed with the exception of “a bit of nonsense” resulting from children kicking a ball into the garden of the supported housing placement [line 297]. The expressed concerns about neighbours were then later labelled as “delusionary ideas” [line 300]. The use of professional language reinforced with the collective “we” in line 302 further supports the claims of the speaker. In effect the speaker invoked his occupational identity as a professional worker to establish what was to be known as objective fact.

There remained a problem however to be resolved in this account to enable it to confirm and establish the category of someone who was to be seen as unreliable due to mental illness. This relates to managing the differences between the account provided by Bill and the one now being provided by the CPN. The CPN account worked so as not to casually dismiss everything Bill might have said previously. The speaker appears to be accessing knowledge

about valuing patient's views in accounts of treatment (Woodbridge and Fulford, 2004). The emphasis on service-user involvement and participation in mental health settings is an increasingly meaningful discourse (Barnes and Bowl, 2000) and one which cannot have escaped the attention of most mental health practitioners. This study in seeking service-user stories may be seen to support service-user involvement and participation. As I have indicated, until recently this has been a relatively rare occurrence in forensic research (Coffey, 2006b; Godin et al, 2007). Professional participants such as Bill's CPN may access background information, related to service-user involvement, to provide accounts for the purposes at hand. The purposes at hand include an awareness of the audience, in the form of a nurse academic, who may be understood to be sympathetic to notions of involvement. The accounts provided may then seek to balance these understandings with occupational identities, which are often at best sceptical of such moves.

The CPN's version was clearly at odds with the account offered by Bill when he expressed concerns that neighbours indeed did hold information or knowledge and used it to make judgements about others. It was also inconsistent with what the speaker later says in the same extract in supporting Bill's view that people with mental illness were identifiable to the local community who shunned them. This problem was actively managed in the account by indicating that "these ideas" [line 304] "are probably emphasising reality" [lines 305-306]. This reformulation blurred the line between what was considered to be delusional and what was to be known as reality. It worked to resolve the problem created by constructing everything Bill said as the result of delusionary ideas. Bill's concerns were constructed as "ideas" rather than the objective versions of reality offered by the current speaker. This can be read to imply that Bill's concerns were chiefly located in his mind rather than more verifiably in the external world.

The resolution offered by the claim that Bill was "probably emphasising reality" also had the effect of contributing to the development of the category eventually accomplished on line 317. That is, Bill's account should not be

taken at face value but rather should be viewed through a psychiatric lens which marks out behaviours and experiences as being coloured by the presence of psychiatric phenomena such as “delusionary ideas”. This formulation is consistent with a number of accounts in the literature in which users of mental health services have noted the readiness of health and social care professionals to depict their experiences of a range of events as being the direct result of psychiatric illness rather than valuing them as objective accounts (Rosenhan, 1973; Mead and Copeland, 2000).

Following on from the claim that Bill was “probably emphasising reality” the speaker addressed concerns about stigma and the public concern about supported accommodation for psychiatric patients being placed in their area [lines 306-314]. These lines implied that stigma was a fact of life and that public concerns can be assuaged with reference to the “support” offered by statutory services. This it was argued has been proven to be the case “because they aren’t seeing (2) people with mental illnesses running around the place” [lines 315-316]. Despite this being offered as proof of effectiveness the phrase in the context of this account highlighted public notions of unruly, chaotic or out-of-control mad people “running around the place”. It effectively achieved a double function of seeking to demonstrate evidence of effective community care but also what might be the result if such care was withdrawn. The CPN closes his turn with the categorisation “these type of people” having established the elements of the category and the professional prerogative for continued intervention.

6.5 A MODEST FREEDOM

Conditional discharge allows greater freedom than continued detention in hospital but also extends control over the individual into the community. Through a number of formal and informal mechanisms workers operate to gather information about the individual’s behaviours that is then used to inform decisions to maintain or terminate community tenure. Scheid-Cook (1993) investigating compulsory community treatment programmes in North Carolina

has noted an emphasis placed on this approach as a least restrictive option for delivery of mental health care. In North Carolina and many other American states compulsory community treatment is mandated by decisions made in public court hearings within the judicial system³³. Conditional discharge in England and Wales however does not have this apparent transparency and instead individuals subject to these orders lack opportunities to challenge the terms of their discharge except through application to the closed quasi-judicial tribunal system. As such individuals have little choice other than to put up with the continued scrutiny for an indeterminate period while living in the community. Resistance is not overtly displayed to workers due to the threat of recall to hospital. Workers are alive to the possibility that service-users can hide experiences by omission and can regard this as grounds for recall. Service-users may approach the telling of their stories of discharge as one opportunity to demonstrate resistance to the aftercare monitoring that is part of conditional discharge.

Service-users held what sometimes appeared to be contrasting sets of views about conditional discharge. In a number of cases participants indicated that conditional discharge was preferable to continued detention and as such they were prepared to do what was necessary to secure this. 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 professional support was perceived by many to suffocate and restrict opportunities for fuller participation in their communities. Questions about thoughts, motivations and personal relationships were seen as intrusive and were resisted, although perhaps not in an overt way given the likely sanctions this may attract.

³³ This is known as Involuntary Outpatient Commitment and unlike conditional discharge continued supervision and treatment involves a degree of overt scheduling; the commitment order being brought back before the courts after an agreed length of time, usually 30 days.

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 more overt attempts at social control. The greater liberty offered by conditional discharge does not reduce the level of social control provided by hospital detention but 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 voluntary or private housing organisations. Social control of conditionally-discharged people is becoming more pervasive and is more subtly applied. Freedoms offered were glossed by workers as limited, restricted or conditional freedoms for the sake of public protection. Research interviews with both sets of participants suggested that the focus of monitoring and support is the maintenance of biological views of mental illness in the form of medication regimes and risk management. This is at the expense of a focus on securing integration, inclusion or social bonding which is seen as secondary to a more pervasive orientation toward what Nicolas Rose calls 'risk-thinking' (Rose, 1998).

Worker accounts construct compliant service-users as "open and honest". This can be read as foregrounding what are to be seen as positive attributes of individuals who successfully achieve conditional discharge and ultimately sustain this through prolonged community tenure. Despite this construction many worker accounts challenge and ultimately can be read as undermining previously provided service-user accounts.

6.6 CONCLUSION

There appear to be at least two types of deviant labels which are available to be assigned to conditionally-discharged people. These are illness labels or criminal labels. Orientation to one or other of these labels in the talk of participants appears to be tactical. The identity laden labels were deployed to meet changing demands within the stories told in research interviews. For instance, where mental illness is fore-grounded in the talk of participants this

was usually to indicate that support, care and treatment were warranted in the form of continued and ongoing contact with clinical teams, supported accommodation or sheltered employment. It also functioned to excuse absence from normative expectations, such as independent living and securing open employment. In effect the mental illness label functioned as an explanation for continued contact with health and social care services that otherwise would not be seen to be socially valued, as it implicated particular negative identity categories. Where criminal labels were fore-grounded in the talk of participants these were oriented toward understandings of completed sentences, time served and freedom and liberty from continued supervision and monitoring by community agencies. The talk of service-users in these instances accessed notions of rehabilitative penal care. This is that having served one's time in detention one should then regain ordinary rights of citizenship. This may function as a form of resistance to continued and ongoing aftercare monitoring. The distinction between these labels is perhaps a small one. In everyday social interaction, service-users are likely to avoid claims to either label (see Chapter 7) 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.

Some participants however indicated that aftercare in the form of prolonged or intensive surveillance contributes to labelling, discrimination and stigma. Establishing supportive social bonds has been identified as a protective factor in reducing risk of future violent behaviours exhibited by people with mental illness (Estroff et al, 1994), although in some cases supportive others may be at increased risk (Estroff et al, 1998). The absence of a focus on establishing social supports was evident in the talk of all participants and, if reflective of the practice of aftercare, may indicate an area for future initiatives in health and social care work.

Social support post-discharge was drawn quite narrowly in the talk of participants. In particular service-users offered little in their talk to indicate

that there was any sustained effort made in this regard. Workers appeared content that the subtle transcarcerative elements of their aftercare functioned to enable them to respond promptly to concerns about increased risk behaviours. Service-user concerns, that public reactions to their condition was problematic or that intensive support may be working to unmask them in their communities, were largely dismissed with recourse to a ready use of psychiatric terminology.

In Chapter 7 I build on this analysis of talk of community return to show how establishing oneself in communities requires the ability to rehearse and deploy social identities in talk. I will show how service-users appear to orient toward notions of social sensitivity in their accounts of return to community living. In doing so I will examine how actors managed identity threats as one way of accomplishing new, emergent and less tainted social identities.

CHAPTER 7: ACCOMPLISHING BEING ORDINARY: IDENTITY TALK OF CONDITIONALLY-DISCHARGED PEOPLE

7.1 INTRODUCTION

In this chapter I will build on my analysis of talk of conditionally-discharged people by exploring the ways in which identity work was accomplished by participants in relation to re-establishing oneself within the wider social setting. As I have shown participants invoke identities in talk for the purposes at hand during research interviews. In this study this has included addressing deviance in the form of criminal offending, admission to the mental health system, discharge and post-hospital aftercare. In each case identities were invoked and deployed to meet the varying demands of the research interview. In other words identities in talk were not fixed but flexibly used for the matter in hand. In this chapter I will show how identities were deployed in the talk of participants to manage the private sphere of the individual.

Mental ill-health can be a very distressing experience for those with the condition, their families and the wider community. Unpredictable and strange behaviours can lead to strains in the social fabric that make up the support network surrounding the individual. Many of these behaviours will have caused embarrassment to the individual and their families. Perhaps most significantly the response of the wider community to such behaviours (and confirmation of contact with mental health services) is often to reject the person or refrain from further contact. It is perhaps understandable then that many people with mental health problems are careful about revealing information about their condition. In circumstances where the individual has engaged in serious criminal offences, which have the effect of confirming public misconceptions about mental illness, it is likely that the maintenance of privacy and decisions about disclosure are constant challenges. The social identity implications of stigma, discrimination and exclusion make the

maintenance of privacy an area of particular sensitivity. In this chapter I will explore how privacy and disclosure were handled in the talk of participants within research interviews. I suggest that the successful handling of threats in talk clears space for participants to deploy emergent identities. The balancing of privacy and disclosure decisions can be seen to be one part of the transition towards full re-integration in community settings.

I have indicated in Chapter 5 that a feature of the talk of people on conditional discharge was the orientation towards progressive directional stories. For the most part accounts indicated greater independence and liberty from the mental health and social care system. In this chapter I return to this idea of directional accounts to examine how notions of transition are taken up in the talk of participants as a type of identity work which progress towards normative roles and 'being ordinary'. One way in which this ordinariness is accomplished in talk is in the telling of accounts which can be read as resistant to the dominant discourse of powerful others. I will suggest that resistance talk functions rhetorically to substantiate claims of ordinariness in the stories of people on conditional discharge.

Discreditable social identities such as mental illness and/or serious criminal offending hold the potential to be highly socially sensitive as I have indicated. I provide an analysis of service-user participants' narratives which indicates that these stories worked to accomplish emergent identities. Discredited social identities were handled in talk by creating distance and difference between current and previous identities. Distance was signalled in both time and space through talk which indicated the index offence as temporally and geographically located. Difference was accomplished by reference to individual moral characteristics in opposition to the more serious (other) cases that populate the forensic mental health system.

7.2 HANDLING SOCIAL SENSITIVITY IN THE TALK OF CONDITIONALLY-DISCHARGED PEOPLE

Returning to live in the community following lengthy detention in a forensic mental health facility can present challenges in managing social interactions. Managing social relationships and the potential for rejection or isolation by other social actors is one area of interaction which service-users referred to in their talk. Service-users participating in this study had been detained in forensic hospitals for long periods of time ranging from three to twenty-five years. In most cases these facilities were distant from their home communities making continued contact with friends and family more difficult. Although there were exceptions³⁴, the criminal offence, conviction and subsequent detention in a secure mental institution had in many instances led to the person being rejected by family and friends. In some instances, close members of the person's social network were victims of the offence. In circumstances such as these there are obvious difficulties in maintaining social networks.

The interview talk of many service-users was concerned with managing the socially-sensitive nature of a forensic mental health identity. Some respondents had changed their names following their conviction and either by choice or requirement, relocated on discharge outside their original communities. These may be seen as ways of managing identities related to the socially-sensitive nature of serious offending and prolonged detention in forensic hospitals. New names in new communities may allow emergent identity work to develop and flourish. There remain downsides to this outcome too however. Distanced from communities and informal networks of support, conditionally-discharged people have to rebuild and create social support afresh. There is some evidence to suggest that they often fail to

³⁴ One service-user participant (SU2: setting one) recounted a story in which he reported being visited by friends and family three times a week throughout his detention in a medium security hospital. This seemed to be very much the exception and more usually respondents talked of very little continued contact with friends or family or outright rejection following their arrest and detention.

achieve this. Gerber et al, (2003) noted that mentally discharged offenders living in supported housing projects had very little contact with community members.

It was also the case that for many respondents there was a high-profile element to their offending histories. Participants reported that events surrounding the criminal offence had featured in local and national newspaper reports, suggesting particular problems for reintegration. For example, some spoke of their notoriety which resulted in visits from the police whenever an offence similar to the one they had committed was reported in their area. This was not only anxiety-provoking but led to strains in their relationships with neighbours and seemed to contribute to their notoriety. This was often precisely the opposite of what many participants sought to achieve on discharge. In this section I will show how the talk of service-users indicated that they were concerned to establish new identities based upon expectations of normative roles and demonstrated awareness of the social sensitivities of managing community return and integration.

Sensitivities surrounding certain types of information are something which has implications for the individual in that they imply risk or threat to identity (Sieber and Stanley, 1988). Identity-relevant information which is liable to attract negative labelling is associated with discrimination, stigma, reduced social capital and exclusion (Thornicroft, 2006). Managing these identity threats is a task which is achieved in the talk of individuals in social situations. One way this is accomplished is to keep some information private. Westin (1967:7) has suggested that privacy is the assertion by individuals to determine,

“when, how and to what extent information about them is communicated to others”.

Privacy management is seen as a dynamic process by Westin in that it is regulated through the control of information for the purposes of securing or servicing role requirements (Margulis, 2003). Some social psychologists have argued that privacy regulation is a task for individuals in situations where for

instance disclosure of normally private information is being considered (Altman et al, 1981). Interest in self-disclosure has led to concerns about variable definitions of the concept which Fisher (1984:278) argues is,

“verbal behaviour through which individuals truthfully, sincerely and intentionally communicate novel, ordinarily private information about themselves”.

This definition itself has some limitations, for instance its emphasis on verbal self-disclosure may be interpreted as discounting written accounts, but for the purposes of studies of talk it serves to highlight the focus on ordinarily hidden and novel information which is intentionally revealed within social situations. These decisions to reveal private information appear to be driven, at least in part, by identity performance and the handling of threats which may result from socially-sensitive information. Altman and Taylor's (1973) initial theorising on social penetration held that people revealed superficial non-intimate details of themselves in early exchanges with the assumption that this was a cumulative and directional process. That is, social bonds deepened over time in part oiled by the incremental and reciprocal disclosure of more intimate information from social actors. This is a view that was subsequently revised to recognise that social actors may engage in cyclical, reversible and non-linear exchanges in relationships (Altman et al, 1981). Recognising that social interaction in which disclosure is achieved has implications for identity, Foddy and Finnigan (1980:6) argued that privacy was,

“the possession by an individual of control over information that could interfere with acceptance of his claims for an identity within a specified role relationship”.

This suggests that privacy management and disclosure of socially sensitive information achieved through talk is a dynamic process and fundamental to establishing emergent identities.

I will suggest here that privacy management is something that is actively accomplished in the talk of people on conditional discharge in at least two ways. The first way in which privacy management is actively accomplished is

in relation to the how and what of revealing identity sensitive information in research interviews. Occasioned interview talk functions to elaborate identity work in interaction for the purposes of laying claim to, or resisting, available labels which are identity-relevant. Everyday reciprocal rules for information disclosure appear not to apply, although a measure of trust in the interviewee/researcher relationship may be necessary. The second way in which privacy management is actively accomplished is in re-telling of events where disclosures to the wider community were warranted. Rhetorical devices were employed in the talk of participants to establish plausible, credible and convincing stories of how the day-to-day management of emergent identities were handled.

In the analysis presented here I will show how interview talk often involves an active process of negotiating the boundary between private and public, determining what identity-relevant information is disclosed and when. For example, during the course of this study some participants disclosed highly personal information such as talking about their index offence. Others however chose not to reveal this information. Access to this information however was handled so that what was revealed about an offence and the positioning of this information within the research interview was functional or action-oriented. In almost all cases where service-users spoke about the index offence they did so after the interview was well established. This usually followed turns in which the alternative versions of identity claims were aired or appeared within stories which established illness claims as credible and warranted. For example in the interview with Maeve (see Chapter 4), she went to some lengths to establish the severity and persistence of her mental distress. The criminal offending behaviour was positioned sequentially to the description of ill-health. This action orientation was aimed at managing the identity-relevant elements of socially-sensitive information. Lee's (1993) concept of sensitivity as threat can be extended therefore to consider identity threats involved in interaction (at least within the interview setting but also perhaps more broadly) which are then handled in the talk of participants.

In the next sections I will show through the use of interview extracts how service-user participants demonstrated and handled emergent identities in their talk to address privacy and disclosure, establish identity in transition and begin the work of articulating new identities in talk.

7.3 “BEING DIPLOMATIC WITH THE TRUTH”: MANAGING DISCLOSURE IN SOCIAL SETTINGS

One way in which awareness of social sensitivity was evident in interview talk was related to how service-users reported their handling of disclosure issues with the wider community in relation to their previous offences and mental ill-health. When handling social encounters, in which the prospect of disclosing past events became a possibility, participant’s accounts emphasised illness. Service-users reported that when called to explain themselves in social situations they did so with recourse to illness rather than criminal offending labels. In most cases participants reported active decisions to keep hidden identity-relevant information in social situations unless it was impossible to avoid. The exception to this was when encountering officials in formal settings for instance when claiming benefits (SU8: setting two) or registering with a new general practitioner (SU2: setting one) where participants reported disclosing both their mental illness and criminal offending³⁵.

The extract presented below is taken from an interview (lasting almost one and half hours) with Tim whom I gained access to in research setting two. Tim was a man in his thirties who had been in contact with mental health services for many years and who had spent most of this time as an inpatient following a number of unsuccessful attempts to live independently. The research interview took place in the living room of the supported house where

³⁵ This seems in part to be the result of individuals changing their names. Interestingly, name changes were explained by service-user participants as being for the purposes of achieving a ‘new start’ and to protect their new identities. However in contact with officials they were required to divulge previous names to enable access to social security benefits or primary health care. They explained that this often resulted in having to account for their decision to change their name, thus revealing far more about themselves than they would have wished or perhaps would have been required to otherwise.

he had been living for 6 months since his conditional discharge. Tim described a strategic approach to managing disclosure of his illness history. In this extract Tim outlined his recent discharge in terms of a complaint about being compelled to accept a supported placement. He constructed his placement in supported accommodation and the continued monitoring by the aftercare team as restricting his socialising options which was a significant concern to him. Tim's account indicated that he was very much aware of available identity labels and he reported adopting a tactical approach to making new friends because of concerns about how his past may be viewed by others.

118 MC: So this time you have come back to live in the [community

119 R: [Yeah.

120 MC: Has that been recent?

121 R: Yeah I got a conditional discharge in January, umm I could've applied for it last
122 August but um, I get my socia- my solicitor that it would be advisable if I applied for
123 it in January because I moved to, I was in [local hospital] and they have places on
124 [street name] and I was in a place called [supported house] and they're basically to
125 show that you are independent and they usually move you on into the community well
126 for some reason with me my experience has been that I went there showed that I can
127 look after myself and um what it takes to you know to be able to run a flat and my
128 social skills were fine you know my domestic skills you know what skills are
129 involved in running a flat etcetera but nevertheless um supported accommodation I
130 took a step backwards by coming here you know and ah it was the wrong decision to
131 make and um I could've easily moved into the community into independent living
132 from a flat which ah you know again like they don't realise that it's going to be years
133 now at least one year two years before I do get independence you know and they
134 don't realise it's a sentence you are under you know it's a sentence. I mean for
135 instance I'm obviously very well stable and ah I go out socialising and I have come to
136 the stage that um I'm talking to people socialising, keeping, being diplomatic with the
137 truth because obviously I don't want to mention my past you know most of, a lot of or
138 some of it um but you know because what's ongoing that's not so much of a problem
139 because if they get to know me then I can sort of you know divulge that information
140 but you know when I can't even bring them back and I have social workers coming on
141 if I stay overnight which is very difficult if you've met someone in the pub so you
142 know how are you supposed to meet you know when you go back to their place how
143 can you do that when you've got to let the Home Office know you can't do it you
144 know so it's very hard even trying to live the sort of life you know um, get um, you
145 know um, doing normal things even you know. (7) [takes a drink of his coffee]

[Tim interview: Setting 2: lines 118-145]

In this extract Tim's account opened with a complaint about the incremental staging of his aftercare monitoring which he argues was unnecessary, having

already proved himself capable of independent living in an interim placement. He outlined the stages he had already completed [lines 121-134] indicating how he believed he had satisfactorily demonstrated his social and domestic skills [lines 127-129]. These opening lines show again the positive directionality and time-oriented nature of conditional discharge narratives that I have explored in Chapter 5. The story was one of achieving incremental improvements which are benchmarks on the path to eventual discharge (Roth, 1963). He likened his continuing aftercare and the placement in supported accommodation as “a sentence you are under you know it’s a sentence” [line 134]. Tim was using the language of the penal system to establish a complaint of unreasonableness in relation to his placement in supported accommodation. The sequential placing of this complaint works to accomplish an interrupted recovery trajectory set up in the previous lines.

Throughout the research interview Tim was concerned to explain his dissatisfaction with the intensity of monitoring and what he regarded as the intrusive nature of supervision in which workers would “pry” [line 112] into his private life. Tim explained too, that having to report his whereabouts was effectively hampering his attempts at social integration. His concern with managing his privacy was not solely focused on revealing information to workers but also on managing identity in other social settings.

Being “very well” was used to introduce the talk about going out socialising [line 135]. Taken for granted notions of being well were accessed here through the use of the directional phrase “I have come to the stage” [line 135], to establish the basis for continued claims of independence which were realised in seeking friendships outside the mental health system. Going out socialising was constructed as part of an incremental process in which Tim had now “come to the stage” of talking to people and getting to know them [lines 135-136]. In such a process he indicated that sensitive identity-relevant information about his past may be understood to lead to premature termination of new friendships.

For some respondents it was the ability to control information about their past that was a pre-requisite for new identity work. Tim suggested that he managed information about his condition in a titrated need-to-know basis. His talk suggested an awareness that revealing too much too soon about his history may prove socially detrimental to him, in that he would not be able to make new friends. He signalled this in an earlier turn in which he expressed his concern that when he had told people about his mental illness, “then they look at you in a different light” [lines 62-63]. This suggested that available negative identity labels resulted from divulging a mental illness in social situations were active within the account. These labels were understood to have consequential effects for those labelled. In such circumstances effort may then be taken in social settings to avoid repeated exposure to these experiences.

This extract indicated the speaker’s orientation to the notion that there were socially-sensitive elements in establishing new relationships. Concerns about negative labels and handling personal information are clearly active. Tim mentioned being “diplomatic with the truth” [lines 136-137] and not wanting to talk about “my past” [line 137] in social situations. He also wanted people to get to know him as a person before divulging information [line 139]. Tim accomplished in his talk a sense of what was required to establish social bonding and integration as a recently discharged forensic mental health service-user. Tim’s account indicated that his awareness of likely negative reaction to disclosure of mental illness was one that he managed in interaction in social situations. However the research interview itself was also a social situation and Tim’s account was itself oriented towards managing the interview interaction by establishing claims for what were to be understood as valued categories. Being ‘diplomatic with the truth’ was one tactic for managing disclosure issues in the world outside the interview whereas within the research interview itself there was also active management of privacy in interaction. In the next section I will show how this was achieved in his talk.

This account established through talk the speaker's identity claim as a person who was no longer in need of continued aftercare monitoring and supervision. This was achieved by foregrounding what was reported as his ability to live and manage his own life independently [lines 123-129]. Independence was a key word in Tim's account; he used it twenty two times throughout the course of the interview. This was often to signal liberty from detention and freedom from continued aftercare monitoring. In some instances Tim categorised himself as an "independent-minded person" [lines 101 and 113] which he elaborated as a category of service-user who wished to live without the interference of health and social care services. Limited in his ability to secure full independence by virtue of the conditional discharge order, Tim constructed the category of 'independent-minded person' as one who seeks or desires this state rather than someone who has already achieved it. This identity-oriented category was an important one for Tim as he contrasted this with another category at other stages of the research interview that is, those having poor illness control [line 95], those who were unable to care for themselves [lines 642-43] and those who were dependent upon others [lines 682-683]. Tim's account therefore was concerned with the problem of establishing the category of independent-mindedness for the purposes of the interview. This was contrasted with the need for continued intrusive support and monitoring by the aftercare team and housing workers, which he constructed as synonymous with long term institutionalised mental illness categories.

Institutionalised categories may include those who lack competence to live independently outside of hospital, see themselves as sick, are passive, helpless, and have lost daily living skills (Townsend, 1976). This category development functioned to establish Tim as capable, rational and therefore able to determine and manage disclosure of private matters in social relationships.

Having established identity claims to the category independence, Tim then moved on to address the dissonance³⁶ encountered in social situations in which he was required to actively establish emerging identities in social interaction. “being diplomatic with the truth” [lines 136-137] involved managing the flow of information about his past. This information it has been argued is highly identity-relevant (Estroff, 1989). Tim accessed common understandings of societal reactions to mental illness in his account to support his decision to initially keep hidden identity-relevant aspects of his past. Having already established through talk his independent-mindedness, Tim used this category to warrant an additional claim, “I’m obviously very well stable” [line 135]. Thus the category of independence was presented as verifiable and credible.

Tim’s claim to the obviousness of his wellness was in part due to his established independent-mindedness but also perhaps as a result of an unspoken assessment that may be perceived to have occurred in the research interview. Tim’s claim to a wellness category was necessary to reinforce his claims to the category of independent-mindedness. This normative category orientation is required in social situations when illness labels are still current and available. The continued supervision and monitoring that Tim was subject to, made available and warranted the use of the label of mental illness. In challenging and resisting this label Tim was required to do the work in his talk of establishing an alternative identity which was realised in the category of independent-mindedness. The statement that his wellness was obvious also functioned to protect the category from challenge. If something is claimed to be obvious to one participant it may be difficult for the listener to question this. This may be particularly so in an interaction where the speaker is expected to hold the floor such as in providing narrative accounts in research interviews.

³⁶ Dissonance in this sense refers to managing social interactions in which maintenance of privacy was required to ensure initial engagement with other social actors while being fully aware that this was unlikely to be a successful strategy for establishing sustained social bonds.

7.4 DISCLOSURE IN THE INTERVIEW

Dynamic handling of privacy through disclosure in social situations involves deciding what to reveal, and when, to other social actors. Tim's account re-told events about a specific social situation, that is choosing what to say about past events when meeting people in the pub. The research interview situation itself is an occasioned social interaction in which participants actively manage their privacy and choose what and when to disclose information about themselves. The extract above is taken from a point in the research interview (approximately 15 minutes into the interview) where Tim had not (yet) disclosed his index offence. To do so at this early stage may have been socially risky or identity threatening. Establishing rationality through convincing narrative or articulate description of events may be one way in which more sophisticated story tellers handle the process of disclosure.

As I have indicated not all service-user respondents chose to reveal details of their index offence. Some did so fully, others with limited detail, while others did not talk about this time of their lives at all. No participants were asked to talk about their index offence at any time during the interview. The choice to reveal this information can be seen as an active one, occasioned by the context of the interview and managed in the talk of participants to achieve or protect identity-relevant aspects of the disclosure. This handling of information accomplished the task of constructing a particular identity. This identity management was not without dispute however and both the social worker and the CPN visiting Tim provided accounts that challenged and resisted his identity work. This suggests that much of the nascent identity work accomplished by Tim was likely to be formed and reformed in interaction with workers as well as the wider community in which he socialised. This dynamic management of disclosure and privacy in interview talk was an important part of the identity work that Tim and other participants accomplished in their stories.

The path towards establishing new and emerging identities is therefore not as straightforward as simply articulating these identities. Instead they are realised and recast within talk where identity claims are at stake. This interactive element of identity formation is ongoing and in some ways may mirror or parallel transitions from hospital to the community, from detention towards liberty and from mentally ill offender towards community citizen. It has been suggested that the deployment of social identities always relates to some matter in hand in talk (Antaki et al, 1996). In interactions with others, Antaki and colleagues suggest, this deployment may be briefly over and done with but can have a cumulative effect. This is a process of assembling, rehearsing and refining identities in talk. Research interviews are a site for sustained attempts at building and using social identities that will ultimately accumulate and be available for use in talk. In the next sections of this chapter I will examine how identity was used in talk with reference to transition and movement towards non-deviant identity labels. I will suggest that this is a necessary and crucial element in the move towards achieving successful community return and full involvement in social life.

7.5 “25 YEARS IS A LONG TIME”: IDENTITY-TALK AS TRANSITIONAL STORIES

I have suggested in Chapter 4 that individuals oriented towards sickness roles in their talk of entry to the forensic mental health system. This functioned to warrant exclusion from performance of everyday roles and was used as one explanation for criminal behaviours. Everyday understandings of illness suggest that role entrance, recovery and role leaving are in most cases, clearly linked (Aubert and Messinger, 1958). The talk of participants was oriented towards these everyday understandings in that positive directionality was one feature of their stories. Their narratives of retold events or expectations of future events indicated movement towards improved health, reduced aftercare and greater liberty. People on conditional discharge can be seen to be between the extremes of indeterminate compulsory detention in

hospital and full liberty in the community. A problem may arise however once the individual has recovered from the acute symptoms of the condition. At this point role leaving is prevented by the requirements of conditional discharge in the form of ongoing treatment and supervision in the community setting. This challenges the use of available deviant identity labels so that for instance participants are required to reconcile continued declarations of mental illness and offender status with attempts to re-establish relationships and work roles in the community.

In this section I will explore how the interview talk of participants achieved the function of signalling identity transition from mentally disordered offender towards more normative identities. I will show how participants made use of previously available identities in their talk as a means of drawing contrast with current identity claims. These more recent identity orientations functioned to achieve distance and difference between older selves and newer emerging identities. In all instances participants articulated newer identities that can be read as relatively mundane. By this I mean that the focus of talk was on accomplishing identities that centred on what I am calling 'ordinariness'.

Ordinariness for my purposes is defined as normative role orientations such as family or work roles and includes self-descriptions in which the speaker makes use of common everyday language to construct identities as being 'average', 'ordinary' or 'normal'³⁷. The work of narratives of participants involved establishing their ordinariness as something which was a product of time and experiences of the forensic mental health system. Estroff (1989) has argued that for the mentally ill as with people more generally, identity is at least in part achieved in interaction. Estroff's contention is that this holds the potential for negative evaluations by others. However identity is an accomplishment and can be worked-up to achieve more positive appraisals by rejecting negative labels and claiming affirmative ones (McKinlay and Dunnett, 1998). Research interviews which focus on conditional discharge are one venue where newer identity claims are accomplished. Major life

³⁷ These terms are categories supplied by service-user participants in their talk to describe themselves during research interviews for this study.

transitions brought about by serious illness, prolonged incarceration and staged community return in the form of ongoing aftercare monitoring are important contextual background for this identity work.

The notion of transition is one that suggests movement. It is perhaps an easy interpretation to view transition as simply physical movement, especially when considering the person moving from higher levels of security through lower levels towards community living. Social anthropological studies of tribal societies have noted that transition in the form of ritualistic rites of passage is a feature of establishing new identities (van Gennep, 1960; Turner, 1969). The experience of living with chronic and enduring illness in post-industrial societies has also been likened to a form of identity transition (Kleinman, 1988; Kralik, 2002). For the purposes of my analysis I will draw upon this earlier literature on rites of passage to embark on an analysis of the identity work that social actors achieve in their talk as a form of voiced transition. That is, how people accomplish through talk, movements in the ways in which they present themselves to others, and what this achieves within the wider social context.

Transition in enduring illness may be triggered by onset of the condition and result in a number of reassessments of identity and life trajectories. Transition toward new identities may be analogous to the process of recovery in the sense that it is about shifting and rebuilding a new sense of self (Deegan, 1993). The need to rebuild identities is itself a result of the biographical disruption brought about by mental ill-health, criminal offending and incarceration and as I have shown is signalled in the talk of people on conditional discharge. For people with enduring mental health problems these transitions can be imposed as society reacts to mental distress by isolating and in some cases incarcerating individuals for treatment and management. In these circumstances re-evaluation of personal and social identities is a significant and ongoing process that commences once the person is arrested, convicted and detained for treatment and continues once discharged from hospital. In this section I will explore how the identity work

implied in these transitions was accomplished in the talk of people on conditional discharge. In Chapter 8 I expand my analysis of transition to consider the ways in which new identities may be conceptualised based upon Turner's (1969) notion of 'threshold people'.

The interview talk of participants functioned to achieve a number of identity-relevant tasks. Participants oriented towards normative identities in their accounts. This was achieved by positioning themselves as someone who previously had mental illness or a history of detention in secure services but who was now different to other people so classed. These identity-relevant aspects of talk functioned to signal the transition from previously available identity ascriptions. Previously available identity ascriptions are those which were not valued by participants and their accounts functioned to create distance and separation from these³⁸.

Distance and separation were achieved by differential use of available identity labels in talk, depending on the purposes at hand. For instance, as I have shown previously, mental illness labels were used to establish and validate absence from social roles and to explain criminal deviance. As I suggested in Chapter 5 criminal offending orientations in talk may be one way of resisting or challenging ongoing aftercare and monitoring by workers. This might suggest a source of extreme opportunism by speakers in simply selecting constructions that best suited their interests. This would be an incorrect assumption however. Rather, it can be seen that service-users in telling the story of past events and current complaints, used those labels relative to the temporality of their accounts. In other words, when describing temporally distant events such as those surrounding the index offence participants oriented toward illness labels. This was particularly evident during early stages of conditional discharge to the community. When narrating concerns about ongoing monitoring, participants oriented towards everyday

³⁸ There is a potential problem inherent in this strategy however which relates to attributable negative moral status. If mental illness is totally rejected as identity relevant, a claim of moral culpability may then be available to be assigned. For this reason overt rejection of mental illness labels is avoided and reference to the activity of professional others in assigning these labels or to mental illness as an historical artefact in the talk of service-user participants can be read as a form of moral safety net.

understandings of recovery and role exit. In part this was achieved by making use of the language of the penal system to establish expectations of liberty from ongoing surveillance. A further tactic was to work-up normative identity orientations in accounts. This functioned to accomplish difference between old selves and emerging newer identities and can be read as seeking to achieve this through claims of ordinariness.

Participants handled normative identity orientations in their talk in a number of ways. Some explicitly rejected or resisted attempts by workers to establish their status as a conditionally-discharged mentally ill person. This was achieved by omitting all mention of mental ill-health or offending and by instead stressing through talk their roles as workers providing for their families [SU12: setting two; SU13: setting one]. Other participants constructed earlier deviant identities as transient, now passed and replaced by new or emerging identities [SU8: setting two; Niall: setting two; Lloyd: setting one]. In each case the stories functioned to establish distance in time and space from earlier available identity labels. This can be seen as for the purposes at hand and in no sense am I suggesting that these identities were fixed and immutable.

Another way of handling identity work in talk is outlined in the following extracts of the interview with Fred. While many participants constructed accounts in which their ordinariness resulted from transition or was to be taken for granted, Fred's account elaborated his ordinariness as a form of resistance. Fred presented himself as unchanged after more than 25 years in the secure hospital system. It was a view that was supported in the talk of workers and demonstrated that constructing oneself as being unchanged is a viable if perhaps not terribly successful³⁹ identity claim for people detained and monitored by the forensic mental health system.

³⁹ Fred's social supervisor voiced this view during the research interview. His view was that Fred in not acknowledging any change in his presentation of self had directly contributed to his continued incarceration. This was because psychiatrists detecting no change in presentation concluded that this was equivalent to no improvement and in such circumstance they could not sanction Fred's discharge.

The interview (lasting almost two hours) with Fred took place in the supported house where he was living since his discharge 4 years previously. Fred was an elderly gentleman who had a number of traumatic life experiences leading up to his eventual arrest and detention in a high security hospital more than two decades ago. He was supported by a resident carer, the social worker from setting 2 and a local CPN who visited him regularly. In the first extract Fred outlined his entry to high security services which he later described as prison-like, heavy-handed and authoritarian. In the second extract Fred outlined his ordinariness which he constructed as a psychological category of personality.

Extract 1.

- 1 MC: I would like to know about your experiences of being in hospital, leaving
2 hospital to come home and what it's been like being out of hospital
3 R: Well I had a bit of trouble with a person and he recommended that I get a shotgun,
4 so anyway I quite legitimately bought a shotgun from a fishing and tackle store
5 without a licence. So I took it back to him, handed it to him and he called the police.
6 So anyway I was languishing in jail for a little while and then I was tried in [city] and
7 um (2) the medico said I was, that I was not myself you see, so the judge said uh can
8 you ah intervene and (2) look after yourself in court? So I said not without your help,
9 so anyway he said okay take him out so that was all I had in court, that's why I'm
10 stumbling a bit on it, and um I went back to jail in [city] jail and a few days later 2
11 prison officers came in. In they came they said get dressed, I said what for where are
12 we going, he said don't ask questions just get dressed, so they bundled me into a car
13 and took me to [high security hospital] where I languished for uh 25 years. Anyway
14 during the discourse at [high security hospital] it came to pass that a psychiatrist said
15 he backed whoever said I was unfit to plead and that I was mad, that was it. So
16 anyway (2) the sojourn in um [high security hospital] I didn't know what the hell was
17 going on half of the time but anyway we'll leave it at that and that's it. Anything else
18 you want to know?
19 MC: So you were in [high security hospital] [for
20 R: [25 years
21 MC: 25 years
22 R: Yes
23 MC: And you didn't know much about what was going on there
24 R: No
25 MC: So what happened then?
26 R: Um well I got discharged and I went back to [local hospital] in [city] and they
27 declared me schizophrenia paranoid. So anyway I'm still hearing these so called
28 voices you know,

[Interview Fred: setting 2: lines 1-28]

Extract 2.

- 358 MC: Have your experiences changed the way you see yourself?
359 R: No I've not changed, I am pretty well the same now as I was when I was 21 in my
360 opinion, I don't bother nobody. I'm probably type B behaviour, not type A.
361 MC: What do you mean by that?
362 R: What type A type B? Well type A is the type where you want everything done,
363 you're on top of other people you rise sometimes to the top quickly but it doesn't end
364 there you die young. Type B can take it in his stride and um that's about it.
365 MC: So you would not characterise yourself as being an assertive person?
366 R: No, no I'm uh I'm pretty easy going.
367 MC: Having been in [high security hospital], having been a mental patient has that
368 changed the way you look at yourself
369 R: No, that's the reason for all the studying and being in the um cold potting shed, the
370 instruments were taken away from me and of course [name] the meteorologist didn't
371 go much on it at all and told them so, he was a lecturer on meteorology in [name of
372 university], he used to visit Europe and different countries to uh discuss the weather,
373 very nice person, really nice person.
374 MC: You didn't see yourself as the same as the other people that you were in with?
375 R: No, I refused to have that. (2) 25 years is a long time, I never thought that at any
376 time I was cracking up, never did, but keeping myself mentally and physically uh
377 informed, that was it.
378 MC: What has helped you to settle here since you left?
379 R: Well as I said, myself really, Type B [laughs] (2) we had a little uh questionnaire to
380 fill-in in the centre for long life learning and we got set this paper, this handout, and it
381 declared me, the lecturer declared me Type B, which I approved of [laughs]
382 MC: So you think it was your own personal qualities helped you settle outside
383 hospital after all those years
384 R: Yes, yes. It may sound like a little boast but uh I think not.

[Interview Fred: Setting 2: lines 358-384]

At the very outset of the interview on line 3 Fred referenced his offence as "I had a bit of trouble with a person" which led him to buy a shotgun. This culminated in his arrest with the result that he "languished in jail" [line 6]. Mental illness identities were used as extra-situational resources in the talk of the speaker and constructed as being imposed by others. The psychiatrist said he was "mad" [lines 15], the local psychiatric hospital had previously "declared me schizophrenia paranoid" [line 27] and another doctor who had said he "was schizophrenic quite sure" [line 35]. The speaker's apparent reticence to accept these identity ascriptions was reinforced in line 27 when he referred to his "so-called voices". The account as a whole however indicated that the speaker did not wish to be known as someone with a mental illness and he was reluctant to claim this identity. Fred's account worked to accomplish a new claim of ordinariness. He did not wish to claim available

identity labels of either mental illness or criminal offending. This can create a problem then in establishing validated and verified role absence. In other words how can one establish alternate identity labels when available warranted labels are rejected? As I have indicated overt rejection of available illness labels may implicate moral culpability and Fred's account worked to manage this by establishing that, while claims about mental illness existed, he himself was reluctant to directly assert these.

Fred's account did the work of addressing the problem of role absence. He rejected available labels by establishing an alternate and superficially viable label. His talk established first that he was to be seen as someone with significant inside knowledge. The length of his detention [line 375], the naming of a well-known high security institution (37 times throughout the interview), the immediacy of his first-hand recollections replete with protagonists names all served to accomplish the identity work that Fred was to be seen as someone whose first-hand experiences gave him standing to talk on these matters. The accomplishment of this knowledgeable person created the space to begin establishing an alternate identity claim. This claim was based upon what Fred constructed as a series of injustices within an uncaring and unsympathetic health and social care system. His references to the 'cold potting shed' [line 369] are related to a story in which he constructed his placement in the potting shed as punishment for asking too many questions within the high security hospital.

Throughout the interview Fred did not at any time directly claim other available identities indicating that he disputed labels of mental ill-health and criminal offending. His talk indicated that he was to be known as a "Type B" personality [line 360] which he contrasted with the more assertive Type A personalities. He was to be seen as someone who saw life as something he could take "in his stride" [line 364] and who was "pretty easy going" [line 366] and therefore in no way out of the ordinary. However closer analysis of the talk revealed repeated references to high security care, psychiatrists, police, the criminal courts system and health and social care professions. His talk

was therefore peppered with reference points to an identity that was situated in the context of forensic mental health service delivery.

Zimmerman (1998) refers to talk with these features as displaying an orientation to *situated identities* in that the speaker makes use of extra-situational resources to portray identity-rich information. Identities deployed in discourse link the functional activities of talk with social structures and institutions through everyday understandings that participants have about them. Participants in establishing the grounds for their account to be seen as credible, explicitly deploy extra-situational references in their talk.

Zimmerman's (1998:88) definition of situated identities as delivering,

“pertinent agendas, skills and knowledge, allowing participants to accomplish various projects in an orderly and reproducible way”,

appears to allow for this treatment. The identity of an ex-special hospital now conditionally-discharged person makes use of these resources to achieve the task demanded by the research interview context. Fred's talk can be read as referencing people, places, events and roles that were required to populate a story of contact with forensic mental health services. This achieved the function of establishing his status as someone who was warranted to talk on the subject. Fred's account also worked however to simultaneously indicate that he was not to be seen as like others who use and inhabit these very same services.

Having shown how Fred's talk functioned to establish him as someone with status to talk I want to now explore how the account also functioned to claim difference from others who inhabit forensic services. For many service-users the device of indicating difference between themselves and others in similar circumstances was a remarkably consistent feature of their talk. As I have indicated the opening lines of this account provides an example of the speakers' resistance to available mental illness and criminal offending labels. Fred's account accomplished the task of establishing him as different to others in the high security system prompting my question later in the interview about his perception of himself [line 358 extract 2]. The claiming of difference

was an artful achievement in his talk and was accomplished in a form similar to what Mishler (2005) has referred to as narratives of resistance.

Fred constructed his identity in talk as one of stoic resistance against perceived injustices. The narrative reads as one of resistance to claims about his mental health and the offence for which he was convicted. Fred insisted that he “refused to have” himself seen in the same way as others detained in the system and resisted this by keeping himself informed and mentally and physically strong [lines 375-376]. This was constructed as being encapsulated within his desire to engage in academic pursuit while detained despite the difficulties encountered. Fred’s talk functioned to dispute claims of mental illness and achieved the task of communicating both the unusualness of his experience and his wish to be seen as “easy going” [lines 366 and 481]. The speaker declared his ordinariness but this functioned to highlight the extra-ordinary, as it was a claim offered despite many years of institutional living in a high security hospital. Detention in high security settings and the implications this has for social identity appears at odds with claims of ordinariness. Fred’s description of his time in the high security hospital depicts an environment which has all the hallmarks of Goffman’s (1962) total institution, initiated by the degradation ceremony of being placed in isolation in “a cell for uh about 48 hours” on entry to the hospital [line 197].

The talk in this interview can be read as a modest display of claims to ordinariness, accomplishing the task of highlighting the unusual nature of what was being said and validating his resistance. This was reinforced by the contrast between Fred’s claim to be the same person now as he was when he was 21 years old [line 359] (a time span of over 50 years) and his talk that indicated his continuing academic studies which implied development and change. On line 405 he acknowledged that he had to learn “to take things in my stride” while in the high security forensic hospital.

Contrary to his claims his talk signalled change and adaptation and was constructed as being a necessary survival step in living within forensic secure

settings. In a study of mid-life women experiencing chronic illness Kralik (2002) described attempts at incorporating this condition into daily life as a 'quest for ordinariness'. The accounts of conditionally-discharged participants in this study can be read in a similar way in that they sought to accomplish ordinariness as a constituent element of a later stage of transition. Fred's account constructed ordinariness as inherent personal attribute which had persisted in spite of his experiences rather than as part of a process resulting from them. Sacks (1992) has noted that in interaction, social actors commonly achieve the everyday business of claiming ordinariness. This he suggests is how,

"in reporting some event, people report what we might see to be not what happened, but the *ordinariness* of what happened"
(original emphasis)

(Sacks 1992:216)

Fred's account achieved the function of setting himself apart from others within the forensic mental health system and perhaps in doing so, more like others outside of this system. Being unchanged worked to signify that there was never anything that needed changing in the first place. The account achieved this through multiple claims of ordinariness such as being 'easy-going' and by accomplishing the alternate resistance identity. This was supported in part by Fred's social supervisor who had known him for many years and presented his claims of being unchanged as symptomatic of mental ill-health.

1 MC: Yeah um so [[Fred]

2 R: Yeah] well I mean because it is about [Fred] being totally different from [Iestyn].

3 With [Iestyn] everything because I've been sitting waffling to you for ages how lots

4 of factors can combine and it's about situations and with [Fred] it is all about

5 separations in that (2) he has compartmentalised just pretty much everything in his

6 entire life and it's all in really clearly marked boxes. With [Iestyn] it is all over the

7 place, you know cannabis, yeah you know what I mean, sort of sleep yeah, money

8 yeah you know what I mean but with [Fred] it's and in essence a lot of [Fred's]

9 functioning remains absolutely intact. He is the same [Fred] now he was however

10 many years ago. He functions well, he organises himself, he's methodical, he's umm

11 (1) logical, he's driven by order and correctness. [Iestyn] sort of muddies along in

12 whatever happens to suit him that day and [Fred] isn't [Fred's] all everything is in its

13 right place, his clothes are always co-ordinated, his activities are always organised to

14 the nth degree, his patterns of behaviour are ritualised, you know what I mean they
15 could not be two more different characters I think and even in terms of the way (2)
16 their similarities are in terms of way the psychosis effects them they both utterly
17 believe, no [Iestyn] is slightly more ambiguous, [Fred] utterly believes that he is not
18 mentally ill, that the voices he hears and will describe to you clearly, he can even do
19 that bit where you ask him to repeat them back to you while he's sitting there and he
20 can do it, are from someone else. Always have been from someone else, could never
21 have ever emanated from anywhere other than this other named individual who has
22 followed him throughout his life casting the most scurrilous accusations [continues]
[Fred social supervisor interview: setting two: lines 1-22]

At the outset of the interview the social supervisor contrasted Fred with another service-user who would later become a participant in this study. On line 2 he indicated his starting position which is that "it is about [Fred] being totally different" from the other participant. The contrast between the participants was elaborated further as Fred was constructed as being, 'absolutely intact' [line 9] and "He is the same [Fred] now he was however many years ago. He functions well, he organises himself, he's methodical, he's umm (1) logical, he's driven by order and correctness." [lines 9-11]. Fred's assertion that he was the same person he was prior to his incarceration was supported in lines 9-10. However the perspective offered by both speakers remained different despite this apparent agreement. The social supervisor described Fred as someone with a mental illness identity both preceding and subsequent to, his incarceration and this challenged Fred's account which was ambivalent in this regard.

Rose et al, (2006) have noted that most research in mental health care is written from the perspective of professionals who determine what counts as evidence and how it should be interpreted. Service-user and carer groups contest the emphasis placed upon particular types of evidence, such as primarily quantitative approaches to data collection and analysis (Slade and Priebe, 2001). One outcome of this emphasis is, as Slade and Priebe (2001) have noted, that quantitative studies tend to privilege physical and pharmacotherapy interventions over psychological and social approaches in their recommendations based on findings. Rose et al (2006) suggest some examples of integrative multiple perspectives research that access the range

of views of various social actors in a particular field of study. The possibilities of multiple perspective research sketched by Rose et al, (2006) are illustrated in the contrasts between Fred's and the social supervisor's narratives.

Maintaining and preserving these dual narratives through first-hand accounts allows as Mishler (2005) intimates, conflicts to be sustained and mediated rather than suppressed. It makes visible, perhaps for the first time, the differing views and tensions that exist between one vulnerable group and those working with them. It also hints at the separate stances regarding identity claims that must be negotiated and ultimately accommodated in patient-worker interactions.

In interaction there may be accommodations between workers and service-users regarding disagreements to repair and allow relationships to persist. This study however did not record these interactions but rather had the opportunity to hear stories in the words of participants which prioritised what they wished to say about conditional discharge. In doing so, rather than examining what actually happens in practice (which would indeed be interesting for a variety of reasons) we are able to examine how social actors construct identities for the purposes of accounting. No claims are made here regarding what this means for social interaction other than for the purposes of storytelling in the research interview context. However research interviews are a form of social interaction in which participants are asked to account for events. The ways in which talk is structured to accomplish the functions of re-telling, and the identity work achieved in doing so, can reveal the types of ongoing work service-users are required to accomplish in the transition from forensic hospitals to community living. This analysis then provides a snapshot of the bigger story of life on conditional discharge.

7.6 RESISTANCE AS IDENTITY WORK

Power and hierarchy in forensic mental services place the patient in a relatively weak position relative to workers. Detention as constructed in Fred's account (and those of many others) was an oppressive experience.

Already socially marginalised Fred produced a narrative which presented the image of the cold potting shed in a high security hospital as one of ultimate physical marginalisation. Excluded from society and isolated in a high security hospital he was further shunted to the isolation of the potting shed. This he constructed as being the result of his resistance of authority, the basis for a further identity claim. Mishler (2004: 2005) has examined patient-physician relationships and the discourse of clinical encounters to suggest that there is a neglect of what he calls 'narratives of resistance' in research and clinical practice.

These narratives suggest a social justice problem for Mishler (2004). His concern is that exclusion of alternative perspectives (as found in service-user narratives) hampers critical discussion about the relationship between ethics and clinical practice/research. These stories Mishler (2005) sees as often being concerned with resistance to physician power and are told by people in marginalised social positions. Narratives of resistance are often moral tales and they may be forms of what have been previously noted as atrocity stories (Baruch, 1981). Seen in this light these narratives accomplish identity work in which the overcoming of seemingly insurmountable obstacles denotes valued social roles and perhaps hints at a claim towards some form of inherent moral fibre. These stories work to portray what any ordinary person might do in similar unusual circumstances. Socially marginalised with little power and near the bottom of the hierarchy of forensic mental health provision, service-users nevertheless accomplish identity work which established claims to ordinariness through resistance.

7.7 "I'VE GONE THROUGH HELL LIKE": IDENTITIES IN TRANSITION

The interview talk of people on conditional discharge displayed a concern to address and resolve the identity-relevant aspects of the historical self while creating the space for the performance of emerging identities. Resistance narratives provide one way of achieving identity-relevant valued social roles in the talk of the conditionally-discharged. Another way in which identity

transition towards socially-valued roles was achieved was by setting up a contrast with others who might be similarly labelled as mentally disordered offenders. This was achieved with reference to what may be called normative or culturally available roles and descriptors. For instance respondents referred to being “laid back” [Brendan, setting one] or “easy going” [Fred, setting two] or focused their talk on work or family roles [SU10, setting 2; SU11, setting one]. These descriptions were to be seen as relevant to how the person wished to be known and were a recurrent feature in the talk of participants. They are also a feature of everyday understandings that are used as labels for socially advantageous or desirable states when called to account for events in a research interview. That is they are identity-rich labels which are accorded valued status and as such are important orientations in talk (Antaki and Widdecombe, 1998). They denote membership of socially-valued categories and as such are important resources for the work of establishing consensus for new and emergent identities.

Stories functioned as a display of previous and older identities of mental illness and criminal offending. These displays were treated as temporally distant however and the function of the talk was to claim newer identities. The stories in these interviews had a transitory quality to them. Where previous deviant identities were acknowledged this often achieved the task of distinguishing them from newer non-deviant identity claims. The contrast between the weight of events that as culturally available information worked to impose identities upon participants and their claims to ordinariness was a striking feature of these accounts. Interestingly while service-users constructed deviant labels as historical, workers oriented towards these as current, thereby challenging emergent identity work. This can be read as emphasising contemporary concerns with risk status and may have been a form of professional identity work. For example, workers descriptions of their work consistently highlighted public protection as the primary focus of their interventions. This functioned to imbue their work with gravitas and by implication heightens occupational claims to be doing important work. Rose (1998) has referred to the rise of risk-thinking in mental health provision as

effectively shifting the focus of intervention away from therapy and towards prevention of untoward behaviours. Godin (2006) has suggested that this has led to mental health workers being so constrained by bureaucratic structures that they are seen as functionaries whose practice is governed by concerns of risk. I am suggesting however, that in interaction workers make use of the resources of a risk discourse to bolster occupational identities which work to maintain their dominance over service-user groups.

There was a poignant quality to some of the utterances of service-users. These encapsulated more eloquently, than this analysis could hope to, the identity work necessary in community return. For example, one participant talked of how in his daily life others in society didn't know him or his history, enabling him to blend in more fully, "I go to the cinema I'm just like a normal person" [Interview SU8: setting 2: line 242]. Perhaps this can be read as illustrative of the performative nature of identity work in community return.

For some respondents it appeared that they were articulating a transitory identity. It was neither that of someone who was an institutionalised mentally ill offender nor a member of the non-mentally ill, non-criminal offending public. This was illustrated in a number of interviews in which respondents attempted to create distance between themselves and other people using the same services. There was in effect the implication that having successfully navigated the system to achieve conditional discharge they could then lay claim to alternative identities that were different and separate from that of someone who had not achieved discharge. These new identities were however flexible, deployed for the purposes at hand and at times, transitory. By this I mean they were subject to dispute, challenge and confirmation. One example of this is in the research interviews with Tim (see section 3, this chapter), his CPN and social supervisor. Tim constructed psychiatric diagnosis and concerns about substance misuse as an area of contention. In their talk the workers challenged and disputed Tim's claims of recovery and independence. For instance his attempts at socialising were not recognised as contributing to his recovery and reintegration but instead dismissed as

“shallow” by workers who expressed reservations about him seeking new sexual partners. In doing so his efforts were effectively cast as indicating a negatively-valued moral status.

Emerging identities were achieved in a highly consistent manner across almost all research interviews. For instance the talk of one service-user participant ‘Lloyd’, constructed other people in secure services as being members of a different category to him in that they were characterised as “criminals”. The interview (lasting approximately one hour) with Lloyd whom I accessed in setting one, took place in the living room of his supported placement which he shared with three other men. Lloyd, who was in his late thirties and from a rural background, had been conditionally-discharged nine months earlier. As we have seen the research interview may act as a place to deploy, rehearse and refine identity talk and in this section I will show how tentative claims may be accomplished in the narratives of people on conditional discharge.

26 MC: I’m happy for you to start where you want to start and tell me what you want to tell me.
27 R: Well what I did was in (2) year 2001 (1) I burned the farm down like, I am telling you the
28 story of it. And I burned the hayshed as well (2) my father went into hospital as well so I
29 burned the farm after all that, after my father went into hospital. I was on my own and I
30 didn’t know what to do with the animals and stuff and I was called up by the police to go to
31 [name] hospital. I was there for 5, 6 months (2) am I going too fast for you?
32 MC: No that’s [alright
33 R: And] umm they shifted me up to [distant district] then to [RSU1], have you heard of that?
34 MC: Yes
35 R: I was there for two and half years (3) then they said I could come down to [RSU2] the old
36 [RSU2] and then I had to move to the new [RSU2] as well then I was in the new [RSU2] well
37 since (2) 9, 10 months something like that in the new [RSU2] as well and then I came to the
38 [house name] here with [providers name] (2) and since that I’ve gone through hell like. (1)
39 Because when I was in [distant district] there was lots of people well criminals there that
40 killed somebody and all that but then you know I haven’t done that like so it’s not fair that
41 you’re in with somebody like that then, its hard then in a way like. (2) Some of the cases were
42 very bad. (7) There’s a bit of information there for you (1) it’s a long story but I know I’ve
43 done wrong but my brothers and sisters and my family don’t do nothing with me anymore.

[interview Lloyd: Setting 1: lines 26-43]

This extract of interview talk followed the opening preliminaries of the interview in which the study was explained and consent ascertained. The narrative can be read as highly task-oriented. It functioned at the very outset to achieve distance in time and space from earlier identities. The speaker

was asked to start where he wished and his initial response was to outline the offence for which he was convicted and placed on the restriction order. This was unusual in this study as most service-users who chose to talk about the index offence did so only when the interview was well established⁴⁰.

The account set the scene by temporally locating it as occurring in 'year 2001' [line 27]. This achieved temporal distance and accomplished the task of clarifying that this behaviour was not current. The detail in these opening lines also established distance in terms of space, the offence happened on the farm [line 27] and was within the context of difficult personal circumstances that challenged the participant's coping abilities [line 30]. This talk placed events as distant and the context as firmly located in another time and place establishing that deviant identity labels that may have been warranted no longer could be said to hold. Constructing events in relation to time and place established room within the story and in effect created the rhetorical space for later identity work in the research interview.

The account worked rhetorically to ensure that this version of events was heard as a plausible one. As Edwards and Potter (1992) have noted, rhetorical devices used in talk help rebut counter-claims and set up current claims as fact by working to establish the version being told as something other than a claim. Lloyd's account accomplished through the use of culturally-validated notions of paying the price for deviance, that older identity labels were to be seen as no longer valid. These culturally-validated notions included removal from society in the form of arrest [line 30], detention [line 31], isolation from his family and community [line 33] and eventual loss of family contacts [line 43]. The story worked to handle potential negative evaluations of previous behaviour by addressing these directly at the

⁴⁰ As I have indicated earlier in this chapter, in circumstances where service-user participants chose to disclose information about offending to me in the research interview it was usually following attempts at establishing illness claims. Lloyd's talk in this research interview may be seen as a deviant case in that his talk did not follow the usual pattern encountered with other participants. Analysis of such cases nevertheless helps to deepen analysis and develop interpretation of everyday displays of understanding of participants.

beginning of the interview. As I have noted it was an unusual tactic but one which was also structured to soften the declaration made.

One way in which the admission of the offending behaviour was softened was that the speaker did not refer to his acts as arson at this early stage in his story (although he did do so later in the account). Admission of arson directly implies criminal behaviour and at this early stage of the interaction it may not have served the purposes of the story. Arson is seen to be a deliberate and wilful act intended to destroy property without concern for the safety of others. It is punishable by law but perhaps more significantly for social interaction it is deviance that is hard to fathom. It is a category which may carry emotional and moral consequences and it was initially avoided by the speaker. Geller (1992:623) in a review of the literature on arson and arsonists reflected what might be seen as culturally and morally-oriented tone when he opined that, "nobody wants these arsonists in our midst".

The speaker instead used a non-technical and perhaps less formal phrase of 'burned' to describe his actions [lines 27-29]. 'Burned' is a much less emotive term and in common use may be seen to be an occupational task, for instance in disposing of rubbish. The speaker handled the identity challenges implicit in admitting to being an arsonist therefore by substituting a more ambiguous term. This enabled the story to progress and allowed the speaker to provide explanations or motives for what otherwise might be seen as culpable deviance.

Acts of unpredictable dangerous behaviour are identity-relevant and the talk of the speaker indicated that these were active within the account. For instance, Lloyd immediately followed his admission of criminal offending with statements that constructed his act as one consequence of his father's admission to hospital precipitating his inability to cope. This account worked to temper the negative value that might be ascribed to someone who has acted dangerously by setting a fire. It did so by portraying an image of a dependent son who was anxious about his separation from his father and

what was presented as his inability to cope with the daily work of the farm. The offence itself was constructed as an aberration brought on by the stresses and strains of an exceptional situation. The account accessed taken-for-granted understandings of these stresses to portray the outcome as unavoidable or inevitable. Although clearly not the case, other outcomes were possible; the talk functioned to convince the listener that this version was a credible account by orienting towards normative role performances of worker and family identities. The offending behaviour was contrasted later in the account with images of diligent worker/family-oriented man and therefore shown to be unusual and out of character. This construction worked in the account to set up the claim that previous deviance was to be seen as an aberration and no longer identity-relevant.

Lloyd reinforced normative orientations in his talk by describing his detention as both unpleasant and as an account of the time served, evidence that he had paid his debt to society. His assertion that he had 'gone through hell' [line 38] is difficult to follow in the context of what was said. The talk moved to further support this claim [lines 39-40] by developing a category of 'criminal' others who were also detained in the same facility. This new category was then embellished as both a significant contrast and further evidence of the 'hell' the speaker had gone through.

The speaker's account achieved identity work by establishing less socially-valued categories of people who were to be seen as unlike him. That is, this was a category of people in secure mental health facilities and it was one to which he did not belong. This alternate category included 'criminals' [line 39] who had 'killed somebody' and as such he should not have been in the same setting as 'somebody like that' [line 41]. The speaker followed this statement with the phrase 'it's hard then like' and that 'some of the cases were very bad' [lines 42-43]. It was not clear whether the 'cases' referred to the people or the crimes they had committed but it was clear that the speaker was presenting himself as different from this class of people who were to be seen as of another category. Categories are inference-rich and members activities category-bound (Sacks 1992). The categories of 'criminals' or bad cases

were used here for the purposes of establishing difference in the grading of deviance. This suggested a hierarchy of deviance in which some categories of deviance are to be seen as more serious than others.

This extract showed how the speaker accomplished his difference from others in the forensic mental health system. The talk in this extract was oriented towards normative role performances of a son and a farm worker. This category was developed and embellished throughout the research interview. Membership of this normative category was achieved by positioning it in contrast to another category which included criminals, bad cases and people who have killed. Lloyd's story did the work of demonstrating his moral worth as a son and as a worker who overwhelmed by events resorted to a dangerous act as a plea for help. The account made use of mental illness labels by citing inability to cope with an unusual set of daily stresses. This signalled that mental illness was implicated in events and also served to suggest that events were beyond the control of the speaker.

Lloyd's account, like those of many others in the mental health system, will have been told many times and perhaps the mitigation has been well rehearsed as a result. This account however functioned as more than simple mitigation. Its aim was to convince not only of the speaker's moral worth but his difference to the other 'bad cases' that populate the forensic mental health system and where he implied he was ill-placed. It can be heard as an attempt to garner sympathy from the listener and was in part oriented towards achieving this given the account of the dangerous behaviour which prompted Lloyd's contact with forensic mental health services and ultimately the criminal justice system. This account worked to achieve a form of moral identity by citing a temporary but explicable (in terms of mental illness) failure in normative role performance.

7.8 SIGNALLING EMERGING IDENTITIES IN TALK

Both Tim (see section 3 this chapter) and Fred (section 5 this chapter) clearly signalled that they were to be seen as different to other people in similar circumstances. Lloyd accomplished similar work in his account. My analysis of accounts suggests that these stories of difference functioned to create the space for new emerging identities. Establishing distance in time and place from previous deviant labels and categories of people who remain so labelled achieved the task of providing sufficient room to begin new identity work in talk. For some respondents (such as those with longer periods since discharge) post-hospital identities were well developed to the extent that orientation towards older negative identity labels was almost completely absent from their talk. For those participants with more recent return to community living such as Lloyd, emerging identities in talk were less well developed, more inchoate. An example of this is presented below in the second extract from Lloyd's interview below. This followed on from a number of turns in which Lloyd described his stay in hospital and multiple transfers between various forensic mental health facilities.

- 76 MC: Can you remember what happened on the day you had the tribunal?
77 R: (5) Well they said that I could go in three or four days after it but I had to wait until they
78 get the staff here and I went then and I came here then. (2) That was April, I've been here
79 since, March or something like that. (2) I've been here since. (2) Now I've started working
80 with you know [name], the manager of the house, her husband I'm working with her husband
81 (2) odd days you know like. Better than sitting in the house all the time, weather is a bit bad
82 now but you know what I mean. (12)
83 MC: What sort of work are you doing?
84 R: Um, cutting branches down and pruning and umm and doing gardening work, doing
85 everything you know, moving furniture (2) yeah a bit of everything.
86 MC: You are used to doing that
87 R: Yeah well I was working on a farm, my fathers' farm, we had sheep and cattle there. I had
88 to do all the animals and feed my father and me when my mother died, my sisters wouldn't do
89 anything, I had a belly-full. And I was working with two of my mates as well on the farm. We
90 had a thousand sheep and four hundred calves so you know it was too much like you know.
[Lloyd interview: setting 1: lines 76-90]

In this extract Lloyd signalled the emergence of a new occupational role [line 79] and supported this by deploying pre-offending identity labels [lines 89-90].

At this stage of the research interview his talk functioned to establish that he was to be known as a worker which he described as being “better than sitting in the house all the time” [line 81]. Sitting in the house all the time can be taken to mean being idle. It was a common sight during my visits to supported mental health community placements to find many residents apparently unoccupied in sitting rooms. Indeed this was precisely the case in this residential setting. Lloyd appeared to be making use of this everyday knowledge of community mental health placements to indicate that he had chosen to be active rather than unoccupied. He indicated that this was despite the worsening weather as winter deepened [lines 81-82]. The identity references in his talk signalled that Lloyd was a worker, active not idle and therefore different to those in similar circumstances to him. It was an emerging identity and one which he developed in lines 84-85 following a prompt about the sort of work he was doing. The work was active, labour intensive and required a certain amount of physical capability. It was also embedded in his earlier identity as a farm worker [line 87], an identity which was populated in Lloyds’ talk with hard work and significant numbers of animals.

In this second extract newer identities emerged and were perhaps less-well established, given that Lloyd was discussing more recent events related to taking on a new job. However his talk signalled movement from identities associated with the mental health system and towards occupational roles which can be seen to be more socially valued. These roles were relevant to older identities as a farm worker. Zimmerman (1998:94) has noted that situated identities in talk connect local performance such as the research interview with wider social arrangements

“through socially distributed knowledge participants have about them”.

I am suggesting that Lloyd was deploying the extra-situational resources needed to accomplish the activity of movement towards a worker identity in

his talk. Normative role orientations in the talk of conditionally-discharged people appear to be deployed to advance claims for new identities.

7.9 CONCLUSION

In this chapter I have shown how privacy and disclosure decisions are handled in the research interview talk of people on conditional discharge. This may provide an insight into how people handle this in other social situations. Research interviews are a particular type of social situation but nonetheless they are a form of social interaction. Participants choose whether to disclose information or keep it private in social situations. The work they do in their talk functions to this end. The purpose of decisions to disclose or withhold private information may not be immediately clear. Within the research interview it appears that talk works to establish the moral status of the speaker. This may be similar to what others have referred to as 'passing' (Goffman, 1963; Edgerton, 1993). I am suggesting a more flexible situated action here in which deployed identity talk works to disclose or maintain privacy for the purposes at hand. It is a to-be-achieved task of the story which may work to prevent the individual being subject to discredited moral status. However these decisions also seem implicated in determining new or emergent identities in talk.

The success or otherwise of establishing new identity claims may in some part be supported or denied by workers in their attempts to provide aftercare. In a number of instances during this research, workers demonstrated scepticism about service-user identity claims to the extent of challenging and at times undermining these claims [Tim: setting 2]. For some respondents their response was to resist professional challenges and persist with the work of establishing newer identities [su12: setting 2] while others clearly resented these challenges but adopted a measured acquiescence to aftercare monitoring [SU8: Setting 2: SU13: Setting 1]. Examination of these resistance narratives and contrasting multiple perspectives may open the possibility of

gaining a deeper understanding of illness and treatment experiences within forensic mental health systems.

People on conditional discharge orient towards normative role identities in their talk as a means of establishing ordinariness. This is in part an accomplishment of the stories told, and is one way of establishing distance and difference between the individual and others within the system. Complete rejection of mental illness labels is however not an option for claims of ordinariness. This may be particularly so in terms of combined mental illness and criminal offending labels. Complete rejection of mental illness labels may open the way for others to suggest a more morally discredited status in the form of badness. There remains a tension here in terms of the relative status of different labels. Mental illness is a condition that is increasingly seen as possible to recover from, although public and professional attitudes about role exit have been shown to be negative. Criminality may be seen as more enduring but it remains possible to achieve role exit through for example, completed prison sentences and rehabilitation.

Normative role orientations were read as being a stage in identity transition performed perhaps for the occasioned research interview. However as elements that were prioritised in the narratives of speakers themselves it is possible that these performances reflect the identity work that service-user participants engage in on a day-to-day basis, as they seek to re-establish themselves as moral credible community citizens living under the scrutiny of aftercare monitoring arrangements. Ordinariness is an active accomplishment in the talk of social actors. It is deployed and worked-up through multiple stages of establishing distance and difference, by self descriptions and by normative role orientations. In the next chapter I elaborate upon my analysis of the data that I have examined in Chapters 4, 5, 6, and 7 with the intention of exploring its relevance to aspects of contemporary forensic community mental health care. I provide further analysis of attempts to accomplish 'ordinariness' in talk by means of distance and difference and suggest this directional movement is a form of liminality.

CHAPTER 8: IDENTITY TALK AND COMMUNITY RETURN

8.1 INTRODUCTION

In the previous chapters I have shown how people on conditional discharge use stories to accomplish identity work. These stories are often rhetorically organised to achieve credibility and standing to speak on the subject at hand. They function as Edwards (1998) has indicated to argue, resist or challenge competing accounts and provide alternative ways of describing things. They are situated accounts related to the business of everyday life and the social practices of participants. These are important foci for ethno-methodologically informed study. Community living raises concerns for those discharged, workers and the community itself. Achieving reintegration and securing community tenure may depend on the provision of credible accounts and establishing viable social identities. Research interviews are a site for accounting for identity threats of deviance and participants accounts work to accomplish being ordinary.

The rhetoric of risk and community safety have been dominant discourses in media reporting (Lupton, 1999; Cutcliffe and Hannigan, 2001), policy development (Goodwin, 1997; Manning, 2000; Bean, 2001) and public responses to mental illness (Repper et al, 1997). These concerns appear to be firmly embedded in the public consciousness. One consequence of this is the negative appraisal by others of those labelled mentally ill (Thorncroft, 2006). People who are successfully labelled both as mentally ill and a criminal offender embody two principal community concerns. These are unpredictability and dangerousness. In everyday interaction with others, an orientation towards either label is liable to result in threats to social identities. One outcome of the successful application of these labels is increased official attention, in the form of sanction and scrutiny from social control agencies.

Unpredictable dangerous behaviours challenge normative expectancies and threaten social order and as such, society is prompted to mobilise and

address these (Dallaire et al, 2001). The consequence of this view of mental illness for the person is prolonged detention, treatment and supervision, justified by the legal and treatment decision-making of workers (Litwack, 1994). Participants in this study, such as Bill (see Chapter 6), had long experience of these responses to their illness and criminal offending behaviours. The accounts can be read as showing awareness of commonly-held information related to mental health workers and their controlling influence over predictions of dangerousness (Pfohl, 1978). As such many accounts work to challenge or resist identity constructions that implicate the need for long-term post-discharge supervision.

Service-users provided accounts constructed to manage the identity threats of dangerousness and unpredictability, related to mental illness. Rejecting mental health labels completely may not be possible due to ongoing supervision, or indeed the benefits that can be derived from this. The accounts offered therefore functioned flexibly to claim illness labels while simultaneously rejecting or challenging competing claims of associated dangerousness and unpredictability. This was accomplished by the use of everyday explanations, referencing shared understanding, related to ill-health more generally. For example, illness stories, biographical disruption and time-oriented directionality were commonly used by both service-user and worker participants to claim illness warrants and notions of movement toward recovery. In this way many of the stories worked to account for untoward events, which led to incarceration and detention in forensic mental health facilities.

One might expect that mental illness and/or criminal offending identities offer little to choose between, in terms of negative social responses. Participants in this study however deploy these identities in the research interview for the purposes at hand. These identities are used flexibly, in part to do the work of explaining absence from social obligations and as a form of resistance to the identity-relevant implications of continuing aftercare.

Mental illness labels become more cumbersome and perhaps even troublesome, as time passes. This seems particularly so when the individual has returned to community living and is seeking to establish new roles and identities in everyday situations. In some cases participants' talk oriented towards criminal offender identities to achieve claims of completed sentences or served time. These were sequentially deployed to establish complaints about continuing and ongoing supervision and monitoring by workers. This was not a universal strategy however. Its use appeared limited to complaints and few participants persisted with this line of argument. More common features of discharge talk included notions of recovery from illness as demonstrated by reduced supervision, greater liberty, personal control over symptoms and accepting responsibility for one's own life.

In this chapter I will first briefly address the links between the macro and micro analysis of social situations. I understand micro-sociology as the being concerned with the micro-processes of social life such as interaction (Knorr-Cetina, 1981). In referring to macro-sociology I mean, the study of society and its institutions. It is my assertion that the micro-sociological analysis of interaction has relevance to the wider macro-sociology of social structures. Following on from this I provide a discussion based on my analysis in previous chapters, which examines how social actors live with deviant labels. I argue that actors keep hidden identity threatening information unless required to provide accounts. I then move on to examine what actors do when attempting to negotiate new identities within the context of inference-rich available categories. I conclude this chapter by presenting an analysis of the identity work of the conditionally-discharged as transitional rites of passage.

In the next section I discuss how conditionally-discharged people achieve social action in their talk in interaction. This I see as a form of social action which connects the individual with social structures such as law, order and what is seen to constitute illness and health. My purpose is to assert that micro-analysis of the talk of individual actors should connect with the wider context for the production of that talk. In doing so it may be possible to

advance broader claims for the applicability of analysis to the wider social group for whom these contextual elements apply.

8.2 TALK AS SOCIAL ACTION

Durkheim (1820/1895) de-emphasised the intent of social actors and instead presented social action as formed and directed by social structures. In this view social structures determine individual behaviour, through the application of values and obligations to create social order. One result of this tradition of sociology has been the focus on the description, categorisation and analysis of social structures (see for instance Parsons (1951) work on social systems)⁴¹. An alternative is to view actors as social agents with the capacity for independent thought and action which is realised in interaction with others.

Talk as the means of interaction is a form of social action which is co-constructed, sequenced and negotiated. It involves the deployed identities and resources of participants and displays of their own understandings of events (Garfinkel, 1967). One view of social structures is that they emerge from the interaction of groups and institutions that make up these structures (Cicourel, 1981). Knorr-Cetina, referring to social order, puts it another way

“social order is not that which holds society together by somehow controlling individual wills, but that which comes about in the mundane but relentless transactions of these wills”

(Knorr-Cetina, 1981:7)

Verbal communication in social contexts is not merely reflective of social processes, it constitutes and is constituted by, these same processes (Fairclough 1989). Many social scientists now treat talk as a form of social action in which people achieve particular functions for whatever business is at hand (Wooffitt and Widdicombe, 2006). Schegloff (1991/2006) has argued

⁴¹ Mills' (1959) provides some critical observations of grand theories and what he sees as the overly structural focus of these in relation to lives of social actors. Put simply, Mills suggests that a concern with higher order 'generalities' of social structure have prevented closer examination of everyday problems (1959:33)

that a central preoccupation of sociology and social theory has been focused on the character of social action and the interactions in which it is embedded. Schegloff argued that conversational approaches to naturally occurring interaction are in part driven by notions of social action achieved through talk. The implied agency of social actors is one which is fundamental to my understanding of the purposes of talk. I have attempted to base my analysis on the resources used by participants and the functions of talk, as evident within the interview interaction itself⁴². I have chosen to focus on what talk is working to do and what it accomplishes within the research interview interaction. Produced for the purposes at hand, occasioned by the context of the research interview, but nevertheless achieving a form of social action, these utterances provide an important analyst's resource.

Identity work of individuals is to a certain extent 'allowed', 'denied' and ultimately negotiated in interaction (Antaki, et al 1996). This is the extent to which identity work is asserted, and supported or directly challenged by others in interaction. Mentally-disordered offender identities appear to be treated as fixed by workers but as mutable by service-users. The rules restricting release, and the conditions placed upon workers and service-users to enable discharge, provide a strong structural element to the social practice of aftercare supervision. However the delivery of aftercare at street level is likely to be determined, by interpretation of workers, in interaction with service-users (Lipsky, 1980). In this study significant variation was seen in how participants interpreted and responded to requirements of the conditional discharge order indicating that agency of actors determined how these structures function. In many instances workers and service-users highlighted concerns that minimal deviations from the requirements of aftercare could result in recall to hospital. Here, however I wish, to highlight an example at the other end of this continuum as a means of showing variances in social practices.

⁴² The extent to which I have achieved this task is to be judged by the reader, however I acknowledge that in places I have made use of external resources in a way similar to Wetherell's (1998) contention that invoking other contexts not directly referred to in the talk of participants is sometimes necessary to advance and deepen the analysis.

The notion of talk as social action is an important factor in connecting micro aspects of social interaction with macro understandings of social structure. Strauss (1959/1997) has argued that individual identities can only be understood in relation to collective activities. Linking the micro of individual identities accomplished in interaction with the macro of collective activities in the form of social structures, is an important step in understanding the production of identity work and the purposes it is put to. Conditionally-discharged people are by no means a homogenous grouping. However there is a collective activity evident in their talk. Their talk constitutes and is being constituted by social practices and perhaps even defines the social structures within which they act. Put broadly, this implies that the identity work that people engage in contributes to the social practices of aftercare, community integration and social responses. This is not to be taken as evidence that discharged people are somehow responsible for these social structures and practices. Rather it implies that the ways in which we come to know what constitutes aftercare is the result of a tension, between how social structures influence the lives of people through social practices and, the types of interactions that make up these structures and practices.

One way in which social actions are achieved is through identity work in talk. Widdicombe has suggested that;

“making identity salient is demonstrably an indexical, local and occasioned matter shot through with speakers’ interests”.

(Widdicombe 1998a:195)

In effect identity work in talk is a type of boundary maintenance in which social structures and practices are continually defined in interaction. The boundaries may shift position from time to time and even turn by turn but they nevertheless create social action, by constituting difference between professional worker, service-user and other social actors. It is an ever-present feature, implicit in the talk of participants and ultimately action-oriented.

An example encountered in this study was one participant (SU12: Setting 2) who was constructed by workers as resisting supervision and pushing the boundaries of the formal requirements of aftercare by travelling abroad without seeking permission. The participant constructed aftercare however as a minor hindrance to his everyday life and exercised significant latitude in his interpretation of the restrictions on treatment and travel. The account he presented portrayed him as 'a family man' (line 289) working to earn money to care for his wife and children who needed occasional holidays abroad. His account was constructed as a form of resistance to aftercare labels. His resistance was actualised in his reluctance to comply with supervisory visits, his regular house moves which he kept hidden from workers, his failure to notify workers of new relationships, new off-spring and his regular foreign holidays. In many instances the aftercare team would only learn of these developments many months or even years later. Workers were greatly concerned about his disregard for the requirements of supervision but argued that they felt unable to act without evidence of increased risk or deterioration of his condition. Neither of these events had materialised and so workers reported having to adjust their handling of interactions with the individual. Agency as realised in his resistance defined the practice of aftercare for him and the workers.

Identities oriented to in stories of research participants are one outcome of the action-orientation of talk. That is, talk provides the means by which social actors propose, negotiate and rehearse identities which enable and determine the rules for social participation. Opportunities to participate socially are to an extent regulated by contingencies involved in the process of conditional discharge and present a number of challenges in establishing social participation, which I now turn to in my analysis.

8.3 RETURN TO THE COMMUNITY: LIVING WITH LABELS

Leaving hospital can be a time of heightened expectation mixed with a reasonable amount of anxiety for the future. Numerous contingencies

external to the person such as how systems communicate and how differences in hospital and home time are resolved, determine how smoothly this process is managed (Heaton, 2001). It has been shown that, for people leaving generic mental health services, trajectories towards discharge are liable to evolve in complex ways, making the provision of seamless care dependent on the flexibility of professional workers (Hannigan, 2006).

Attempts at securing first-hand accounts have largely failed to provide the types of micro-level analysis of community return and aftercare, which allow deeper understanding of the processes involved (Coffey, 2006b). Grusky et al (1985) have argued that it is the micro-level features of relationships that are likely to reveal the level of community adjustment among individuals with enduring mental health problems. I would go further and suggest that it is through analysis of talk, in interaction, that re-integration and inclusion in social settings can be most usefully examined.

An important part of these micro-level analyses is examining the social practices of people engaged in these processes. An understanding of post-discharge adjustment to community life is contingent on displays of meaning, and the identities people construct. A number of socially approved vocabularies feature in the talk of participants. These include illness claims, talk of recovery and orientations to normative roles. These indicate the types of work that social actors do in pursuit of integration attempts on return to community living. When called upon to do so, social actors work to account for their actions. They do so while actively managing social sensitivities and privacy. This work is achieved in interaction and is concerned with negotiating alternative social identities as a means to overcome the negative effects of deviant labels. These aspects of the ordinary and mundane everyday experiences of social interaction are crucial to sustaining community tenure. Although similar aspects of community return have been explored with other groups (Edgerton, 1993), the hidden and hard-to-reach nature of forensic populations may be why they have largely eluded investigation.

Edgerton's (1993) cultural anthropology study of a cohort of people with learning difficulties examined their adaptation to community living following discharge from one long-stay institution. He makes the point that, in the initial period following discharge, much of the talk of participants was concerned with passing and denial, in efforts to handle the identity threats associated with detention and learning disability labels. Subsequent follow-up of this cohort however at 10 years and at 20 years showed that passing and denial became much less of a concern as participants improved their social adjustments. Edgerton (1993) provides a rich picture of the everyday tasks which, previously institutionalised, discharged people must accomplish to sustain community tenure. Identity performance following discharge is crucial for smoothing transition and establishing tenure in social settings beyond the institution. The accomplishment of identity in talk does not occur in a vacuum, it is achieved through interaction with other social actors. Conditionally-discharged people, called to account for the circumstances of their discharge in a research interview, demonstrate "indexical, local and occasioned" talk that functions to deploy identities (Widdicombe 1998a:195).

The negotiated nature of identities in interaction also allows for their flexible deployment. In their stories participants make use of normative identities (such as normative role expectations of worker or parent) and non-normative or deviant identities (such as those indicated by accounts of illness or offending). The use of these identities in talk appears to be related to tacit knowledge of participants. Switching or movement between the deployment of different identities in talk requires accounts to be offered. In offering accounts participants were concerned with establishing their illness as mitigation and achieving identities that accomplished transition towards more mundane or 'ordinary' presentations. Scott and Lyman (1968) have suggested that for those who are successfully labelled, there is some social advantage to be gained from this accounting.

"those persons labelled as mentally ill may relieve themselves of the worst consequences of that label by recognising before their psychiatrists the truth value of the label, by reconstructing their past

to explain how they came to deviate from normal patterns, and by gradually coming to give acceptable accounts for their behaviour”

(Scott and Lyman, 1968: 54)

The implication of Scott and Lyman's (1968) argument is that through acknowledging the label, the person may reduce the more negative effects of direct social control. This may be true in respect of contact with professional workers, such as psychiatrists, but there are also more subtle negative effects, which might arise in everyday life. In everyday situations plausible accounts and non-deviant identity work are required to enable the person to establish social relations and pursue re-integration. Challenges to identities may occur in social interaction, and conditionally-discharged people show they are attuned to the implications of these. Accounts offered by participants were rhetorically organised to manage identity threats implicit in their stories. Stories offered were concerned with establishing authenticity of accounts and credibility of the account giver. This seems particularly necessary in mental illnesses, which are associated with irrational and inexplicable behaviours, and where rationality might be called into question. Godin, et al (2007:465) have reported that workers all too readily challenge truth claims of service-users, who themselves were concerned with workers' (mis)representations. Issues of credibility, validity and which account gets heard may therefore be recurrent concerns for service-users in continuing contact with workers.

One way of living with deviant labels of mental illness and criminal offending is to keep these hidden (Link et al, 1989). Participants' accounts demonstrate an awareness of the likely negative effects of disclosure of illness and offending. These accounts indicate that the management of disclosure and maintenance of privacy was a recurrent concern in everyday interactions. In interaction with others, social actors can determine what to reveal and what to keep private. The decision to conceal identity relevant information is itself an active one on the part of discharged people. This implies a concern with the likely effects of disclosure, in relation to negotiated identities, and subsequent negative consequences for re-integration. Participants reported negative

effects of disclosure such as losing employment, being refused day services and limitations being placed on attendance at educational programmes.

For participants the disclosure of deviance is socially sensitive and this can be seen in how this was handled within the research interview itself. Disclosure was handled rhetorically and was sequenced in accounts in relation to claims of illness and mitigation. Claims of criminal deviance were thus softened by the production of accounts which explained and evidenced prior claims of mental ill-health as mitigation.

Mobilising mental illness labels however is not without its problems and can create an enduring form of social prejudice in which identities are seen to be cemented in place, and as such intractable (Perlick et al, 2001; Kelly, 2005). Mental illness can be seen to denote not only irrationality, dangerousness and chronicity, but also a belief that the mentally ill should exercise some control over their behaviour and bear responsibility for what they do (Hayward and Bright, 1997). Mental illness as an explanation or plea for mitigation may not therefore function uncomplicatedly in social interactions. For the purposes of securing treatment, making a plea in criminal court or for securing release through the Mental Health Review Tribunal, mental illness is a necessary identity claim. In the wider community, following release, it has limited utility and participant accounts functioned to establish distance in time, place and difference of the speaker. I return to these aspects of talk and expand upon them, below.

One outcome of the socially-sensitive nature of combined mental illness and criminal offending identities is related to attempts at privacy management. Participants reported relocating outside their originating communities and adopting new names, in efforts to maintain privacy and increase their chances of successful community re-integration. To an extent privacy management remained within the control of the person to determine what, when and who to reveal information to. However there are a number of occasions when this control over privacy was removed either directly or inadvertently by workers.

For instance, participants indicated that they were directed by workers to reveal illness and offending histories to prospective employers or intimate partners. As a result, some chose to remain unemployed, or not to seek an intimate relationship. Regular visits by workers and police officers as part of multi-agency public protection arrangements had in-effect unmasked individuals to the local communities in which they lived. This had significant effects in terms of ongoing negotiated identity work and preferred, or imagined, trajectories.

The accounts offered by participants displayed preferred trajectories or what might be construed as positive directionality (Gergen and Gergen, 1983). Stories focused on improving mental health and increased liberty from aftercare and monitoring services. These trajectories signalled positive and assertive action on the part of the speaker in securing improved health and establishing community tenure. They functioned to deploy narrative identities of recovery and rehabilitation (Davidson and Strauss, 1992). Time is therefore an important feature of these stories. Time served in hospital while detained, time spent since discharge from hospital and notional time remaining before an application to have the restriction order removed, were all consistent features of talk. The implicit understanding was that time spent in hospital suggests resolution of illness and rehabilitation of criminal tendencies. More pointedly perhaps for people leaving hospital, the discontinuities between hospital and community time are brought to bear in complaints of delays once conditional discharge had been granted. These delays lead to increased anxieties about obtaining discharge. The stories of delays also work to imply that workers are not as attentive to their work as they should be. Service-user stories undermine workers' credibility as the providers of authentic accounts by highlighting errors and missed opportunities in the work of planning for discharge. Accounts present discharge as a potentially straight-forward end-process in the illness/recovery trajectory, unnecessarily complicated by the inattention of workers.

The notion of a progressive trajectory is however far from the reality of the lives of participants. Positive directionality in effect glosses the earlier negative events in the lives of participants. The negative events of mental illness, and the associated criminal offending behaviours, were constructed as biographical disruptions (Bury, 1982). Biographical disruptions were described as critical junctures in the life of the person and were used in stories to do the moral work of providing a counter-balance for criminal offending behaviours. Disruptions to life trajectories are used in stories to mediate in determinations and negotiations of deviant identity. These stories were occasioned by the context of a research interview but nevertheless may be available for telling in other situations in which accounts are required. It is likely that participants may be required to provide accounts in interaction at numerous times during their day-to-day lives. Where disclosure of deviance cannot be avoided, biographical disruption may be one device which allows discharged people the opportunity to present previous events as temporary, distant and caused by the unusual confluence of biological and situation-specific factors (Davidson and Strauss, 1995). This is a construction that is readily available in the psychiatric literature and forms the basis of what is termed 'psycho-education' of families and sufferers of serious mental illnesses (Barrowclough and Tarrier, 1992). Displays of being ordinary are worked-up in this construction of life events affecting normal day-to-day living so that they can be seen as something that could happen to anyone.

8.4 "I'M STILL CLASSED AS A DANGEROUS PERSON": NEGOTIATING NEW IDENTITIES

Multiple contingencies influence not only the course and trajectory of mental illness but also the lives of those with the condition. To some extent these trajectories are mediated by workers as social agents enforcing control and monitoring. Post-discharge trajectories are in part determined by the person themselves in how they assimilate and re-integrate through establishing viable identities in interaction. These trajectories are also in part determined by contingencies outside the control of the person, leading to a sense of

precariousness in accounts related to community placement. For instance, securing and maintaining suitable accommodation that meets the needs of the individual is a significant task for workers. If a placement fails to provide for the health needs of the individual, or if it militates against those needs, then recall to hospital may be instigated, despite their being no deterioration in mental health or identified increase in risk behaviours. This scenario, both real⁴³ and imagined, had the effect of undermining, delaying or completely derailing trajectories.

Transition and changes in social identity are always implicated in life trajectories (Tew, 2005). Life trajectories involve significant movement between life stages, changes in social situations, the need to overcome hurdles, or address contingencies such as illness and health (Jonsson et al, 2001; Kralik et al, 2004). These events can be critical junctures in passing from one life stage to another. These transitions frequently involve changes in how the person is seen by others or how they see themselves (Pearson et al, 2004). To some extent life is made up of smaller or larger transitions, requiring smaller or larger movements in identities. These changes are ongoing, day-to-day, negotiated and flexibly deployed in talk for the purposes at hand. In terms of managing the return to community living and achieving successful re-integration, this identity work is particularly important. I have shown that one way of achieving this is through claims of ordinariness in the talk of discharged people.

Ordinariness appears as a resource in the talk of participants. Participants make use of normative role understandings, by orienting to these in their talk, as one way of accomplishing identities of ordinariness. Normative knowledge is invoked either explicitly or implicitly by participants for the purposes at hand.

⁴³ For some participants this scenario had happened and remained a concern for the future. For instance SU10:[Setting 2] had been returned to hospital following an assault on him by a drunken neighbour, on the basis that the situation might escalate and that he had the potential to respond in kind, to continuing threats from this neighbour. His social supervisor reported that he was actually very well at the time and had shown great restraint in the face of an unprovoked attack. However, much to his chagrin, he was recalled to hospital and spent many months on an in-patient ward where it was determined he should not return to his flat and new accommodation was sought on his behalf.

In my analysis of talk in this thesis I have tried to be mindful of Widdicombe's (1998a:195) invocation to

“treat the status of normative knowledge as a participants' concern while being cautious of it as an analysts' resource”.

It seems however that participants make use of a number of strategies in talk to accomplish new emergent identity work. This is, at least in part, to address everyday understandings of mental illness and criminal offending labels. The move towards independent community living requires a move away from these previous identities, towards new or emergent identities in talk.

In research interviews, participants made use of these strategies to achieve the task of separation and distance from identities that were available and might be attributed to the speaker. Participants demonstrated orientations which were constructed as exceptions to the general rules considered to apply to mentally-disordered offender identities, and which would otherwise be commonly understood to pertain. These rules include expectations of unpredictable, irrational, dangerous and discreditable behaviours (Dallaire et al, 2001).

These general rules were noted by participants as problematic when trying to re-integrate, establish new relationships, and generally adjust to life outside of a forensic hospital. This was highlighted by Dave a man in his early 50's who has recently been discharged from medium secure hospital following many years in high security settings.

252 MC: how do you see yourself now?
253 R: well [Dave]
254 MC: the same [Dave] who went into [high security hospital]?
255 R: well no, I don't like the way system works like but there's nothing I can do about it is
256 there? As long as people like leave me alone and don't bother me like I'm alright like. What
257 you've done in the past sticks with you all the time, you know um, I'm still classed as a
258 dangerous person cause if I wasn't dangerous I wouldn't have anybody with me would I so it
259 just shows along that way that people still don't trust me like, that's why I said about the
260 system.

(Interview Dave: Setting 2: lines 252-260)

Dave appears to be concerned that categories assigned to him, such as 'a dangerous person', can continue to present inferential problems once applied. This appeared to be a recurrent feature of the talk of people on conditional discharge. As I have indicated, participants attended to this problem in their talk by constructing past behaviours as mitigated by illness.

Widdicombe (1998b) has also noted that there is always something at stake in talk that accepts or rejects particular categorisations. Much of the talk of participants was about accepting or rejecting generalisations about particular identity labels. Differences between available social identities, in the form of negative value labels, and emergent personal identities of actors, create the need for accounts. This is because identities worked-up in interaction are always open to further negotiation in cases where apparent identity problems exist (McKinlay and Dunnett, 1998). Being seen as a mentally-disordered offender is problematic in certain circumstances, such as making new friends or attempting to secure employment. New identities which are deployed in the context of discharge however may be challenged in light of previous labels.

How then is this move toward emergent identities accomplished in the talk of participants? My analysis suggests that the temporal nature of accounts were used to locate illness and offending at a distant point in time and space. Distance was placed between the speaker and illness/offending behaviours which were constructed as being characteristic of particular categories of (other) people. These accounts functioned to indicate that the previous dangerous behaviour was temporary and no longer current.

Participants sought to place distance between earlier discreditable identities and those that they were constructing as current in a number of ways. These were by reference to time, place and difference. Each of these elements occurred in the interview talk of participants. The reference to time in talk not only placed the events as being distant in time but also emphasised time passing. Time passing was used to show movement towards recovery and greater liberty. Highlighting distance in time from events works as an attempt

to avoid negative social evaluations. Recovery, greater liberty and the avoidance of negative social evaluations are proxy measures for non-deviant identity labels being worked-up in the talk of participants.

Stories of previous deviant identities often emphasised place together with time in stories. Place refers to talk that references the situatedness of previous identities therefore demonstrating that these identities are no longer valid or that they were transitory. Stories frequently place events in a particular place such as city or town where the index offence occurred. Events were presented as biographical interruptions and their purpose was to orient the listener to them as unusual, out of the ordinary and temporary.

An emphasis on time and place as distant is unlikely to be successful in achieving permanent distance between previous untoward events and claims of new non-deviant identities. This is because concerns about the inherent character of the person are still likely to feature in any inferential resources deployed by other social actors. It is necessary then for conditionally-discharged people to establish distance, by means of difference. This involves talk that references negative identity categories of others, and presented as inherent to the personal make-up of these others. They function to place the speaker in direct and socially advantageous contrast to them. Snow and Andersen (1987:1349) refer to this as “associational distancing”. This they suggest is what happens when a claim to a particular social identity may not be substantiated due to an association with people who are negatively evaluated. The individual will then attempt to distance themselves from that class of people. Participants in this study distanced themselves from others in the forensic mental health system and more generally, forensic patients as a social category. For the claims to ordinariness to work it was necessary for participants to achieve this distance between themselves and others who might be similarly categorised. Snow and Andersen (1987) have noted that a claim to a particular identity is contingent on imputed identities of others who are similarly classed. Distancing then becomes a strategy to draw distinctions and show identity difference.

Category affiliations involve potential costs as well as benefits. Snow and Andersen (1987) suggest that individuals can dissociate from a general social category or from specific groups within a category. It may be difficult however for conditionally-discharged people to dissociate from the general group of people classed as mentally disordered offenders. One reason for this is because they remain subject to aftercare, supervision and monitoring. Aftercare was seen as intrusive and threatening by some but at the same time the benefits associated with close attention from health and social care workers were acknowledged. Wholesale rejection of mentally disordered offender status may lead to problems in reconciling current levels of help and support. Participant's identity-work however appears to strike a balance between full acceptance and rejection of these labels. McKinlay and Dunnett highlight that talk in interaction is a means to achieve just this,

“there is a sense in which people can self-ascribe social characterisations while at the same time, avoiding the implications which go with those characterisations”

(McKinlay and Dunnett 1998:36)

No participant described themselves under the general group term of mentally-disordered offender. However, in most cases participants described, without prompting, the circumstances of their offences which had led them into contact with the forensic mental health system. These circumstances clearly implicated a mentally-disordered offender category. Categories are inference-rich resources to be used in talk to account or explain past or present behaviours (Sacks, 1992). They are conventionally associated with particular activities or qualities. This association can also be inverted, that is, qualities or activities can invoke category ascription. Some participants sought to create distance between themselves and other groups within the category. For instance, Lloyd's (setting one) account (see Chapter 7) attempted to dissociate himself from parts of the category of people detained in the same setting as him. He placed some distance between himself and the 'criminals there that killed somebody' which he constructed as 'bad cases'. Widdicombe (1998b) has noted that strategies used by participants to warrant

non-membership of a category are designed to resist some inferential consequences of characterising oneself as a member.

This strategy of distancing was also employed by other participants who had indeed killed somebody. In these instances the strategy was to show difference in terms of other qualities. For instance, one participant (SU2: setting one), portrayed himself as hard-working, 'working in industry for forty years' (line 662). His account presented him as a working class family man who busied himself cooking and cleaning while detained in hospital. This description of himself was contrasted with others in the same setting who he described as 'not clean' (line 640), had no work experience and were generally unlikely to keep themselves busy.

The work accomplished in the talk of participants was not only focused on distancing them from previous identities. For this to be successful it was also necessary to highlight new identity work as one part of the transition from hospital to community living. Ordinariness is an emergent identity but it is also very vague. Its vagueness relates perhaps to the inchoate nature of identity performance among people who are conditionally-discharged. These identities are not fully realised and remain subject to challenge, negotiation and ongoing revision. To an extent they require more opportunities to rehearse and work-up these identities in interaction. This may be particularly difficult for people with mental illness and criminal offending histories who are often the most socially isolated people in society. Previous studies have highlighted the social isolation of people discharged from forensic mental health facilities (Gerber et al, 2003). Social isolation and social exclusion reduce opportunities to try-out emergent identity work in talk with other social actors.

8.5 ACCOMPLISHING NEW IDENTITIES: THRESHOLD PEOPLE

Arnold van Gennep's (1960) anthropological analyses of cultural practices among African tribal peoples prompted his contention that important life passages consist of at least three phases, with attendant rituals. These are, the separation phase, the transition or liminal phase and the re-integration or incorporation phase. van Gennep observed that passages from one age to another or one occupation to another are a feature of life in all societies. He argued that in all cases the individual is 'modified' by these passages through stages, and from moving from one group to another. This modification is essentially one of social identity, how one is seen and perceived by others. The *separation* phase involves the detachment of the individual from earlier (fixed) points in the social structure or cultural conditions. The *liminal* phase is an in-between phase or what Turner (1969:95) referred to as 'betwixt and between'. The *incorporation* phase sees the person re-fixed within the social structure with a new or changed identity.

Victor Turner's (1969:95) study of the Isoma rituals of the Ndembu people in Zambia characterised those in the liminal phase as being in-effect 'threshold people'. He suggested that threshold people were ambiguous and concerned with creating congruous selves, through establishing new roles or emphasising existing ones. They have unanchored identities and as such their status is expressed by symbols within society such as the uncertain nature of their community status. This notion of threshold people is one I will return to later in this discussion but before I do, I wish to flesh out the idea of transition and its identity-relevant aspects.

For Turner and van Gennep, transition is marked by ritualistic and symbolic processes which are aimed at sustaining *communitas* (social relationships). Their focus on primal cultures suggested that transition is about movement from the profane to the sacred or from positions of low status to ones of high status. This movement is attended by culturally-prescribed rituals that afford

the sense of shared experience which is seen as a necessary ceremonial requirement of major changes in life status. The processes which Turner and van Gennep investigated were related to significant life events, such as birth, puberty, child-bearing and death. These are significant life events within any culture and give rise to rituals among people across the globe, where they retain a sense of the sacred. Schouten (1991) argues however, that modern secular societies lack the shared sense of rites of passage that van Gennep and Turner studied. In modern societies people experience more isolated liminal states with fewer supportive rites of passage. While supportive rites of passage may not feature in the same ways in western societies, it is still the case that transitions are commonly held to occur in movements between life stages, for example from adolescence to adulthood (Webster et al, 2004). These transitions remain a fundamental opportunity for changes in role performance and identity. Similarly, transitions between states of health and ill-health, or between status labels, will involve identity and role performance changes (Kralik, 2002).

Role entry, recovery and role leaving in mental illness and criminal offending, imply changes in personal and social identity (Aubert and Messinger, 1958). These transitions are different to the supportive rites of passage described in classical anthropological studies in a number of ways. They are not usually actioned by the involved individuals themselves but imposed by others. The transition is also not one which fits with the expectations of individuals with regard to their life trajectory. They are clearly cast as biographical disruptions by participants, and lead to prolonged attempts by the individual at restoring a form of stasis.

The transition for people detained and treated in forensic mental health facilities is imposed to a greater or lesser degree by the combination of law and psychiatry. These transitions do not have the same weight of public or collective support that may be seen in celebrations of puberty or birth in tribal rites of passage. In many ways they are hidden, often strategically and tactically from public view by workers, families and the person themselves.

For instance, they take place in distant institutions, surrounded by high walls and fences to maintain security and to discourage public scrutiny. Transition events are effectively cloaked in secrecy by workers, a combination of real concerns for confidentiality and a historical concern with privileged access to information that traditionally attends occupations in these facilities (Mercer and Mason, 1998; Kirby, 2000).

My analysis suggests however that transitions retain some important similarities with non-secular rites of passage. These transitions involve the culturally-prescribed rituals, symbols and ceremonial qualities that are a feature of movements from previous identities to new or emerging identities. I am suggesting that social and cultural processes still require and demand that deviance, once successfully labelled, is controlled by formal means. The occasioned talk of people on conditional discharge can be read as describing formal rites of separation, liminality and incorporation.

Separation involves loss of identity. This can be abrupt and lead to ruptures in links between the self, family and the community. It involves alienation, punishment, and journey. It is characterised by losing friends, termination of a previous self and changing name or appearance (Vollm et al, 2006). For people with mental health problems and a history of criminal offending, the index offence and the immediate aftermath can be characterised in this way. For example, it is physical in the sense that people are removed to prisons or hospitals and ritualistic and ceremonial in that there are formal procedures such as assessment in hospital or a court appearance (Holstein, 1993). There is in-effect an enforced physical distancing and separation from family, friends and the wider community. The stories told by participants described previous identities in contrast with current identities, suggesting that a clear separation had occurred.

The *transition*, or liminal, phase is the in-between stage. People on conditional discharge have been classed as mentally disordered offenders, and as such, experience liminality through detention, treatment and ongoing

aftercare monitoring. Previous identities are challenged, newer deviant identities are imposed and must be accommodated. This was described as a period of confusion, testing, learning new ways of being and of indeterminate identity. There may be positive outcomes for the person too. Some participants reported that their time in detention led to new revelations such as discovering a new skill, spiritual awareness or personal truth. For some the experience of arrest, conviction and detention were reported as significant turning points in their lives. Detention in a forensic hospital often leads to increased scrutiny and examination of the self by the person themselves and by others. For example, participants describe professional input as including intense observation and regular challenges to their view of the world. It is painful and uncomfortable, and in many ways it appears to be viewed as an ordeal. This is both physical in terms of the restrictions on liberty and effects of treatment, and mental in terms of the degree of attention placed upon the person's thinking and motivation. The person is required to change or alter his/her thinking and behaviour. The degree to which they are successful, or indeed convincing others of this success, is often crucial in creating the opportunity to move to the next phase of treatment. Participant accounts were structured to achieve credible stories of change and improvement across time while detained, to support claims of difference between previous identities and those that were current.

I have previously likened the final transition phase of incorporation to the movement from hospital to community living (Coffey et al, 2007). However further analysis of participant talk has led me to revise my thoughts somewhat. My initial observation suggested that the ritualistic, ceremonial and symbolic events surrounding the Mental Health Review Tribunal could be viewed as emblematic of movement into the incorporation phase. However it appears from analysis of the talk of participants that those who have left hospital continue to be engaged in a process of establishing and verifying new identities. Liminality appears to be a continued feature of the identity talk of those on conditional discharge. They sit on the cusp of achieving new social identities, restrained by the continued requirements of ongoing supervision

and their own success at achieving full integration into social life. Identity is a work in progress. They are in-effect threshold people.

I am suggesting that conditionally-discharged people are *active* threshold people, engaging in repeated forays into the territory where identities are rehearsed and formed. These forays, limited as they are by social isolation, suggest incorporation and reintegration of identities. For instance, some had established new occupations, acquired new property and furnished themselves with new names. These can be seen as symbols of movement of status. It is a form of what might be called, pre-incorporation. It is an early stage in gaining full acceptance into new roles that eventually might be realised by complete discharge from aftercare monitoring. Schouten (1991:421) has suggested that liminal people engage in what he called 'identity play'. This, he argues, is part of the process by which liminal people 'formulate, elaborate and evaluate possible selves'. Many of the accounts provided by service-user participants functioned to formulate new identities. Deploying a new identity however is not a simple or straightforward transaction. Participants showed awareness of challenges, in the form of worker accounts, which provided alternative constructions of identity claims.

Incorporation in classical anthropological studies is the phase in which the person moves from isolation to return to contact with the wider community. They do so with a new identity forged in the crucible of the liminal phase. The person may receive emblems of their new status in the form of new clothes, a new name and keys to their new home. It would appear that for some, preparation for leaving hospital and returning to live in the community may be a new beginning. The help of services in the form of finding somewhere to live, or purchasing furniture, represent important events in this process. My analysis however suggests that, rather than these being a sign of established new identities, they appear instead to be emblems of a 'pre-incorporation' phase. This is a stage in which the individual is engaged in arranging the material and emotional supports necessary to fully re-establish themselves within society (Barrera and Ainlay, 1983).

Emblems are not sufficient in their own right to signal new fully-fledged identities. The individual has to go about the work of accomplishing new identities in new social settings. Identities achieved, in the relative safety of a closed environment, must then be handled in interaction with the wider community. Deviance in the form of criminal offending, mental illness and incarceration must be reconciled with the societal requirements of normative behaviour. The person is challenged in their everyday contact with the wider community, to accomplish identities and to sustain these in the face of competing available labels that are liable to be imposed upon them by others in society. The requirements to pass, manage sensitive identity-threatening information and to determine when disclosure or privacy is appropriate, form an important element of their social practice. These feature as crucial junctures in the continued trajectory towards incorporation. Incorporation in its fullest sense may be achieved only by successfully achieving new roles and identities, which are less vulnerable to challenge. Trajectories outlined in the accounts of participants were always incomplete. Many were prepared to wait and see what the future would bring, while others imagined a continuing path away from control by forensic workers. Overall however, stories of participants oriented towards positive directionality in the form of absolute discharge, removal of supervision and severing of contacts with the forensic mental health system.

The alternative may be what Gomart (2003:17) refers to as a 'generous constraint' or what I have called a modest freedom. This is constructed by workers as the least restrictive option of providing psychiatric care, and perhaps more relevantly ongoing monitoring in the community. This can be read as a transcarcerative project, employing ever-more diverse and subtle means of control of the mentally ill. In no sense is this meant to suggest a central, top-down orchestrated control of the mentally ill. It appears rather that workers themselves have constructed, in interaction, their own justifications, determinations and motives for the provision of this modest freedom. This however has not been the focus of this study. I have instead attempted to examine the everyday displays of understandings of a much neglected social

group. The identity work that people do in their talk when accounting for offending, detention, treatment and ongoing aftercare, indicates the complexity of the day-to-day work required in accommodating the challenges of reconciling past and future selves. To achieve this modest freedom they must establish distance from previous labels, accomplish new identities and deal with competing versions that arise in interaction.

8.6 CONCLUSION

Talking about aspects of social lives which otherwise would remain hidden may lead to difficulties in conducting research in particular social settings (Lee 1993). This suggests that identity threats are implicit for some social actors, in determining whether to participate in research interviews. Choosing to participate, however, does not diminish the need to manage identity threats that might still arise in research interviews. Participants explicitly acknowledged in their accounts that they were aware of social sensitivities associated with identities such as that of mental patient or criminal offender. These sensitivities are culturally available aspects of identity that both service-user and professional participants orient towards in their talk. The context in which service-users had been approached to participate in a research interview as someone on conditional discharge was important in this respect.

The interview talk of service-users functioned to account for past experiences as well as orienting towards managing the likely threats that this talk might imply. Participants accomplished identities in talk which depended on the claim that illness warranted otherwise culpable behaviours. They established the accounts as authentic and themselves as credible narrators, as a way of managing implied threats associated with the status of a mentally-ill person. This talk therefore achieved at least two separate tasks, first to manage any implied threat within the interview situation itself and second to account for how threats are managed outside the interview in the day-to-day life of living on conditional discharge.

The tasks accomplished in talk suggest movement, change and transition in how the person is to be seen by others. These others include the interviewer, for whom the talk is presented but perhaps also more widely, the professional and lay audiences that may eventually access the account. The talk indicates positive directionality, by temporal positioning of the speaker in contrast to earlier identity labels, or others using the same services. Rhetorical devices designed to rebut alternative versions were employed to achieve this.

Conditionally-discharged people orient towards mental illness in their talk for the purpose of laying claim to available dispensation and to achieve moral work. This is not an uncomplicated relationship however. Differentially deployed identities require awareness and defence against competing versions. For example, talk that oriented towards mental illness identities and or references to criminal offending behaviours was closely followed by talk that signalled the speaker as having met societal expectations, such as paying the required price in terms of loss of liberty. In effect the work of displaying mental illness identities or criminal offending identities can be seen as a preamble to declarations of atonement which work to weaken competing versions. These stories adhere to normative vocabularies of social practice but the emerging identities which they presage are, so far, vaguely elaborated.

Research interviews in which stories are told may be unusual occasions for the production of accounts. They cannot be said to be naturally occurring and may result in set-piece performances for interviews. This suggests some limits to the transferability of findings from analysis of these forms of talk. In this thesis I have tried to acknowledge the context and occasioned nature of the production of accounts. I have argued that despite the limitations of research interviews, and without access to other naturally-occurring interactions, the performed identities in talk of people on conditional discharge (and those charged with their monitoring and supervision) provide evidence of the ways in which accounting for forensic labels are handled in social situations.

The continuing negotiation of identities with other social actors may smooth transitions towards community living and even enhance the person's prospects of successful re-integration. At the level of social structure it is possible that the agency of the individual, typified in social interactions with more powerful workers, will lead to surface change in how these structures deal with people subject to their power. Workers' accounts indicate variance in how people are responded to in that they are conceptualised as either passive recipients of care or active partners in recovery. Given that most service-users in this study have been unable to shake off the labels and associated consequences of mental illness and criminal offending, it would appear that deeper structural change is unlikely to occur as a result of the simple expression of agency. Overt as well as covert social control, in the form of a transcarcerative project, appears instead to be steadying its grip upon the conditionally-discharged. They, for their part, must make the most of the modest freedoms this allows.

CHAPTER 9: CONCLUSION

9.1 SUMMARY OF THE STUDY

People on conditional discharge have experienced complex mental health and social problems and community return is a particularly vulnerable time for them. Many of their efforts are spent in establishing viable identities that are negotiated in interaction with other social actors. Opportunities to negotiate identities can be limited given that many experience reduced prospects of establishing support networks.

The study on which this thesis reports set out to explore identities in the talk of people conditionally-discharged from forensic settings to community living. People classed as mentally disordered offenders are often viewed in the literature in relation to problems they pose in terms of behaviours and social control needs. There is much less attention paid to problems associated with their material survival or indeed their interactions in social life. In examining this latter aspect of social life I have used an approach underpinned by ethnomethodological theories of actor's displays of everyday understandings of life events. Social interaction in the form of narrative talk has been viewed as a vehicle for achieving identities in interaction and the functional nature of this talk has been treated as analysable in these terms.

Research interviews have been viewed as providing one site for social interaction and the production of identity talk. Identity talk is seen as being flexibly deployed for the purposes at hand. It works to account for previous behaviours and to deploy emerging selves. An attempt has been made in this investigation to use the participants' orientations as the focus for analysis. In doing so my analysis makes visible for the first time, the types of identity work forensic service-users engage in when talking about living outside of hospital.

The social and policy contexts of return to community living, for people with combined mental health and criminal offending histories, has been addressed. The continuing focus on the delivery of mental health care in the community is an important context here. The successful labelling of deviance, stigma, discrimination, and the relevance to social identities were examined, to establish the contextual background of living with mental illness. Living with mental illness in communities was shown to involve multiple challenges to social identities.

The provision of intensive continuing supervision and monitoring of the person is a distinctive feature of conditional discharge. Ostensibly this supervision is to enable supported return to community settings. It is however chiefly determined by concerns about public protection as much as the social and health needs of the individual. A theory of transcarcerative social control was used to elaborate the context of conditional discharge in which the individual is kept under one form of surveillance or another (either directly or by proxy) by health and social care agencies.

A possible negative outcome of continuing involvement with mental health services is difficulties in establishing social inclusion and building social capital. The identity-relevant aspects of contact with mental health services as well as combined illness and criminal labels were considered, in my analysis, to be particularly salient. Lee's (1993) treatment of social sensitivity as identity threats was invoked as a way of thinking about research on otherwise hidden and hard-to-reach populations. Forensic mental health services are frequently shielded from public scrutiny due, in part, to a concern to maintain the confidentiality of those using these services. Nevertheless these services, and the individuals using them, can attract high-profile media attention, making the protection of privacy a priority.

An account of the research approach, research governance and issues in gaining and maintaining access was presented. The rationale for an interview study of narratives of conditional discharge was discussed. This included the

expressed intention to explore the action-oriented nature of talk and thereby to shed light on the concerns that the responses of discharged offenders were constructed to address. The two research settings were introduced and described and an outline of the multiple stages of negotiating access to the settings was provided. Due to changes in management and street-level personnel, access had to be continually re-negotiated and research objectives reaffirmed to ensure an adequate research sample could be obtained. Analysis of fifty-nine audio-recorded and transcribed interviews with twenty service-users, and twenty-one workers was described. The initial discussion on social sensitivity was extended to analyse practical problems of access to, and participation of, respondents.

In the following four data-based chapters the identity talk of conditional discharged people was examined. My analysis was presented using a temporal line commencing with entry to the system and progression towards eventual discharge. This analysis showed how individuals accomplished movement from deviant identities towards emerging non-deviant selves. Accounting for previous untoward behaviours with recourse to sickness labels as mitigation was a consistent feature in stories. Establishing standing to talk on the matters in hand through the use of rhetorical devices was also an important strategy. Notions of time passing and time served were significant features of talk. This functioned to show a directional movement towards recovery and greater liberty from services and constructed participants as moral protagonists.

A number of service-user participants reported benefits of conditional discharge and aftercare monitoring including rapid responses to deterioration in their mental health and immediate access to a hospital bed. There were however unexpected effects of aftercare and supervision described by participants. These showed an ongoing concern with the level of intrusive supervision and negative effects on social inclusion.

The transition towards community living required service-users to manage social sensitivities associated with deviant labels. Active privacy management was evident within the interviews and reported as occurring in interactions with other social actors. This handling of socially-sensitive identity performances played an important part in creating the space in talk to begin outlining emerging identities. These were seen as an attempt to achieve displays of mundane aspects of everyday life which I have called 'ordinariness'. Displays of ordinariness were worked-up in talk through multiple stages that involved establishing the credibility of the speaker and the authenticity of accounts, creating distance and difference to others with similar labels and claiming normative roles. In Chapter 8 this analysis was extended to consider how talk is a form of social action which functions to manage the problems of living with deviant labels in the community.

This final chapter of the thesis draws attention to the original contribution of this study and suggests some key implications for practice, research and education in forensic community mental health and the wider community mental health arena.

9.2 CONTRIBUTION OF THIS THESIS

The original contribution of this thesis lies in making visible otherwise hidden aspects of the lives of conditionally-discharged individuals. The stories people tell about the process of discharge reveal critical points in their recovery trajectories of which they have first-hand experience and which have not been previously collated and examined in this way. This study has examined, for the first time, the types of 'identity work' which discharged people must do to enable social integration. This has been made observable by presenting significant extracts of transcribed talk and subjecting this to an analysis which explores its action-oriented nature.

This study has shown how conditionally-discharged persons are purposeful in providing accounts which are aware of competing versions. These worked to show that the accounts were convincing and credible alternatives to dominant

professional discourses. These accounts were also oriented to ideal outcomes of therapy and supervision in that they demonstrate directionality towards recovery and liberty. I have shown in contrast that professional accounts negatively categorise service-users and may even be ambiguous about possible outcomes of treatment and supervision.

The talk of conditionally-discharged people was concerned with providing accounts which deal with the problem of a mentally disordered identity. This was achieved by accounting for previous categorisations, by demonstrating progress towards recovery, by claims of ordinariness to achieve distance from past identities, and by rhetorically managing competing claims. Identities in talk are never fixed in place however. They are flexibly deployed to achieve whatever business is at hand. They remain subject to alteration, based upon the challenges and refinements that occur in interaction. This study has shown for the first time how this flexible deployment is part of the negotiated work of identity performance which conditionally-discharged people must do. These are not deliberate manipulations displayed by pathological people but rather the everyday actions engaged in by all social actors in developing, rehearsing and deploying identities in interaction. The stakes in ordinary everyday interaction are relatively small and involve minor challenges and setbacks to the continued success of engagement with other social actors. For those with already sticky deviant labels, the stakes are considerably higher. The success or otherwise of their community return and their attempts at integration appear to hang on whether they can accomplish viable identities to enable them to pass.

A distinctive feature of this study is that it has made use of multiple views of mental health care and in doing so has shown how service-users and worker's perspectives of the same events deviate and at times overlap. Mishler's (2006) observation that dual narratives of similar processes allows conflicts to be sustained and mediated rather than being suppressed is one that is relevant here. This thesis has shown how separate stances regarding identity claims are present in the talk of both patients and workers. It

suggests that these must be negotiated in face-to-face interaction between these groups and ultimately accommodated within their interpersonal relationships.

Although it was not a specific focus of this study, this investigation found that the transcarcerative project of workers has evolved in ever-more subtle ways. The conditions placed on the discharge of restricted patients are often overt and communicated to people via their plan of care when leaving hospital. However workers report a more covert use of extended systems of monitoring through relatives, neighbours, housing workers and day care workers. Service-users themselves have some limited awareness of these systems. These covert systems were implicitly supported by the selective use of voluntary organisations and private companies that were willing to comply with information requests and the active rejection of those organisations that failed to meet these needs. This study has (unexpectedly) added to our understanding of the myriad ways in which supervision and monitoring of the mentally ill is being extended and achieved by street-level workers.

This investigation has shown that the exercise of institutional power permeates the lives of people on conditional discharge at the level of talk in interaction. Discharged people have oriented towards the relevance of this power and the social pressures associated with deviant labelling in talking about episodes from their lives. Resistance to institutional power in establishing claims of ordinariness or in formulating complaints about discontinuities in discharge planning are features of their talk.

Similarly workers show in their talk, as agents of social control, how they ascribe and maintain what is to be known as deviance. Analysis based on the data collected suggests that this was accomplished through the use of categorical devices. These categorical devices included reference to mental illness and criminality. They worked to invoke particular identity ascriptions that indicated the need for social control measures. In these ways the analysis has shown how social structures are embodied in instances of social

interaction and to an extent opens up these occurrences for further investigation and analysis. The analysis suggests how actors invoke, and make relevant, social structures in the course of their talk. Through the analysis of actual occurrences of conduct in research interview interactions I have attempted to provide a detailed exposition, “rather than just a sense of how the world works” (Widdicombe, 1998a: 197). I have argued more directly however that it is through talk in interaction that these structures themselves are constituted and made known to social actors.

9.3 AREAS FOR FURTHER INVESTIGATION AND IMPLICATIONS FOR RESEARCH

I make no claims here to have advanced broader theoretical understandings of the sociology of identity. I have however shown how those successfully labelled as deviant can contest these labels and advance competing definitions of self. I have also shown how they go about assembling a basis for a claim to non-deviant identity. Future research could usefully explore the relevance of this finding in the talk of other institutionalised deviant populations such as released prisoners.

This research has paid careful attention to the stories of service-users and professional responses to them. It has revealed the work that discharged patients must do to achieve integration and the difficulties which aftercare itself may cause. This suggests a number of important areas for professional education and practice development. These include: workers’ support for preparation for discharge, building of emotional and relationship skills to facilitate integration and a clearer explanation of the requirements of aftercare.

It is crucially important for mental health workers to recognise that establishing viable identities post-discharge is an important factor in the social reintegration of discharged patients. As such workers have an important role to play in this area of support for people leaving hospital. Given the

directional nature of service-user accounts it would seem pertinent for mental health workers to facilitate access to the means of achieving recovery and liberty. One aspect of recovery which appears to be important is related to the attitudes of workers towards the possibility of recovery. Educational programmes for workers could usefully address notions of therapeutic optimism to help build sustainable recoveries (NICE, 2002).

This study has shown that much of the focus for aftercare is placed on supervision and monitoring of service-users. Material supports such as accommodation are prioritised by workers with these concerns in mind. Less emphasis is placed upon emotional and social support needs to the extent that no participants made reference to these aspects of aftercare, even when prompted. The opportunity to benefit from reciprocal social relationships is an important aspect of achieving social capital and may provide longer-term community tenure. It is a focus for practice that should be prioritised by workers to better facilitate recovery and sustained community adjustment.

The potential of studies on interaction between patients and clinicians has still to be fully realised. The micro-analysis of face-to-face, naturally-occurring interaction in mental health settings may help workers to better understand communication in clinical settings. For example, Seale et al (2006) have shown that psychiatrists profess patient-centeredness in research interviews but observations of their practices in clinics (Seale et al, 2007) showed obfuscation when responding to patient complaints about medication. Coffey and Hewitt (2008) have shown that mental health nurses and voice hearers, when interviewed separately, express discordant views about the helping behaviours of the former. A conversation analytical study has shown that patients' attempts at discussing psychotic experiences with their psychiatrist led to difficulties as the doctor hesitated or attempted to avoid this discussion (McCabe et al 2002). Researching communication between patients and clinicians in community settings is difficult from a practical perspective and is unlikely to link intervention with therapeutic outcome (McCabe and Priebe, 2008). However such studies can provide useful insights into the turn-by-turn

negotiated nature of face-to-face interaction. Further studies can inform and develop clinical practice and enable improvements in awareness and communication styles of health workers (Elwyn and Gwyn, 1999).

Cook and Wright (1995) have noted that systematic, sociologically-informed exploration of community mental health care has not reached the heights achieved by similar investigations of institutional care. It remains the case that the investigation of various aspects of community mental health care could benefit from this type of study. One example is the push towards more coercive legal powers for mental health professionals as evidenced in the revised Mental Health Act. In a move that mirrors the powers of Section 41, this allows for compulsory treatment of mental illness in civil (noncriminal) cases in the community for the first time. This can be seen to effectively counterbalance the increased use of community mental health care by extending the powers of the psychiatric professions beyond the walls of the institution. It suggests a move from overt controls as evidenced by locked doors or perimeter fences towards more covert controls of medication and the threat of increased sanction in the form of removal to hospital.

Mental health nurses working in hospitals are in close proximity to service-users and are available to monitor, supervise and administer treatments twenty-four hours a day. Mental health workers however cannot be present to monitor and supervise individuals around the clock when they live in the community. The current study noted an increasing use of nonprofessional resources to achieve this monitoring and reporting. I have suggested that this is a transcarcerative project. However this area of practice could usefully be further explored from a service organisation perspective to establish what practices are commonplace, how widespread they are and how they vary and in what instances. Equally it would be useful to begin to explore how service-users themselves see this widening net of supervision and monitoring.

One concern that has been expressed about similar moves towards compulsory community treatment is with regard to the issue of reciprocity

(Eastman, 1994). This is concerned with limiting the liberty of people for the purposes of providing services which themselves may not be evidenced to achieve improvements in health or risk behaviours. My analysis suggests that these services can have iatrogenic effects such as increasing social isolation. Restrictions on liberty through ongoing supervision for the provision of poorly evidenced services may, albeit inadvertently, militate against positive outcomes. It may be timely for further investigation into the use of compulsory community treatment.

The participants in the study reported in this thesis were a heterogeneous grouping. Some had been arrested, convicted and detained many years ago in high security institutions where they were isolated. In these institutions any expectation of discharge and reintegration was downplayed in favour of a custodial milieu. Other participants had been detained locally in lower security settings and had retained some expectations of cultural and social contacts with communities and families. These expectations included that they would be discharged and many report how they benchmarked timetables for discharge with reference to others detained in the same setting. It has not been possible to determine how different histories of institutional and community mental health care have shaped the social mobility of people leaving forensic in-patient settings. Longitudinal studies of similar cohorts which examine a variety of health and social care outcomes would be very useful in this respect.

This study has presented one aspect of the discharge of mentally ill people to the community. It has opened up for analysis a hidden aspect of the provision of services to a group of forensic service-users. Completion of this study will form the basis for future studies of transitions between hospital and home at post-doctoral level. One area planned for future investigation is that of peer-supported discharge which is receiving increasing attention in the international literature (Solomon, 2004; Woodhouse and Vincent, 2006). Peer-supported discharge involves the provision of advice and befriending services by lay-people, with experience of mental ill-health, as either an alternative or as a

complement to formal services. A recent study has shown that this type of support can increase the social networks of people with enduring mental illnesses (Castelein et al, 2008). It is not yet clear however what the extent of these services are in the UK, what elements of the service (other than the presence of a lay-worker) distinguishes this provision from formal provision, how different service elements interact to provide continuity of care and how they are experienced by participants (Berzins, 2006). Comparative studies of health outcomes would be enlightening. Perhaps more interestingly a micro-analysis of service-user and workers interactions would help to determine how, in negotiated turn-by-turn interactions, actors address social control measures and achieve agency. Research of this nature has the potential to increase understanding of the face-to face contact of social actors with treatment systems and may help to inform and develop community mental health policy that is truly responsive to their needs.

The research on which this thesis reports has shown that conditionally-discharged people have a range of needs which are not directly addressed by current systems of aftercare. Professional workers are acutely focused upon risk management strategies and prioritise concerns with public protection. Achieving forms of surveillance beyond the walls of the hospital is a recurring concern for workers. Less attention is paid to what service-users say about their discharge and adjustment needs. Re-integration and adjustment to community living is however a constant feature of accounts of people leaving hospital and is oriented towards achieving normative roles. In their day-to-day lives the accomplishment of 'ordinary' identities in talk is a continuing and necessary task in securing successful community return.

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APPENDIX 1: ORGANISATION OF SEQUENCING OF WORK

February 2002	Interview for PhD and formal registration
March 2002	First formal meeting with supervisor, commenced reading for theoretical and methodological background
May 2002	Commenced access negotiations to setting one and to setting two Attended Master Class on Passive Minimalist Interviewing presented by Kip Jones from De Monfort University
June to September 2002	Multiple failed attempts to meet with gatekeepers in setting one. Eventually meet face-to-face in September. First meeting with gatekeepers in setting two.
October 2002	Meeting with Clinical Director in setting one to negotiate access.
October 2002	Meeting with whole team in setting two to outline my proposal and negotiate access. Attended Master Class on discourse analysis presented by Glyn Elywn and Lesley Griffiths.
December 2002 – January 2003	Preparing funding application for support through the PPP Foundation for a Nursing and Allied Health Professional Research Fellowship
February 2003	Preparation and submission of LREC application to IMH committee
March 2003	Attended the IMH LREC committee and my application was approved.
April 2003	Application to PPP Foundation unsuccessful although the peer reviews were positive. INVITED SEMINARS: Presentation on community forensic mental health nursing to nursing conferences in Osaka and Tokyo
May- June 2003	Preparation of Department of Health Forensic Programme Responsive Funding Scheme award application.
June 2003	Meeting with CPN team in setting one to facilitate access. PUBLICATION: Chapter on working with mentally disordered offenders in the Handbook of Community Mental Health Nursing.

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September 2003	First service-user interview conducted.
October 2003	Application to DoH Responsive Funding Scheme unsuccessful. Peer and service-user reviews were positive however.
December 2003	Commenced work on background literature review of research of forensic service-user views.
January 2004	LREC application to Bro Taf Committee. Second meeting with team in setting two to negotiate access.
March 2004	Attended meeting of Bro Taf LREC and application was approved.
April 2004	NHS Trust R&D application submitted. Further meeting with CPN team in setting one to negotiate continuing access.
May 2004	Meeting with senior gatekeepers in setting two to secure support for R&D application.
June 2004	CONFERENCE SEMINAR: Presented seminar on narratives of conditional discharge to 4 th Annual conference of International Association of Forensic Mental Health Services in Stockholm. NHS Trust R&D approval granted.
June to September 2004	Conducting service-user and professional worker interviews.
October 2004	Further meeting with managers in setting two to negotiate access.
December 2004	INVITED CONFERENCE SEMINAR AND PLENARY: An overview of policy, practice, education and research in community mental health nursing. Presented with Ben Hannigan to the 25th Jubilee Congress of the Dutch Union of Social Psychiatric Nurses (NVSPV). 9 th and 10 th December 2004. VU University Amsterdam
January 2005	Application to local authority social services research committee for approval to access social workers as participants in setting two. Approved with no changes. Meeting with the social workers in setting two to negotiate continuing access and involvement of this group in identifying

Appendix 1: Organisation and Sequencing

	potential study participants.
January to April 2005	Continuing to identify participants, conduct interviews and complete transcriptions.
March 2005	Further meeting with CPN team in setting one to negotiate continuing access and discuss/resolve issues regarding lack of new participants. Commenced preparation of paper on hidden-populations and social sensitivity as background to understanding access issues and reticence of potential participants.
April 2005	Attended Master Class on Narrative Analysis presented by Catherine Kohler Riessman
May 2005	PUBLICATION: Conference paper on community mental health policy in the UK worked up with Ben Hannigan and submitted to Dutch language journal, <i>Sociale Psychiatrie</i> . Chapter on care planning for mentally disordered offenders in Tummey's <i>Planning Care in Mental Health Nursing</i> Submit 'Researching Service-users Views of Forensic Services' paper to <i>Journal of Forensic Psychiatry and Psychology</i> .
June 2005	Attended Master Class on Narratives presented by Elliot Mishler First meeting of the Friday discourse group established by Lesley Griffiths and myself.
June – September 2005	Continue to identify potential participants, conducting interviews and completing transcriptions. First annual report to NHS R&D committee.
September 2005	Paper accepted for publication in <i>Journal of Forensic Psychiatry and Psychology</i> .
November 2005	Presented draft of background paper on social sensitivity to the Friday discourse research group.
December 2005-March 2006	Continuing to identify potential participants, conduct interviews and complete transcriptions.
March 2006	Paper published in <i>Journal of Forensic Psychiatry and Psychology</i> .
April 2006	PUBLICATION: chapter Community Interventions in Forensic <i>Mental Health Nursing: Interventions with People with 'Personality Disorder'</i> INVITED SEMINAR: "Researching Forensic Mental Health

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Populations: Sensitive Topics in a Hard to Reach Group.
BSA Medical Sociology Wales Study Group.

- May 2006 Final service-user interview completed bringing total service-user sample to 20 participants.
- June 2006 Final data collection completed with interviews of CPN and social supervisor of last service-user participant.
Presentation of paper *Transition and identity: Conditional discharge stories* to the summer meeting of Mental Health Nurse Academics UK
- July 2006 Completion of all transcriptions.
Submission of application for 3 month Sabbatical Leave to commence September 2007.
- August 2006 Annual report to NHS R&D committee.
- September 2006 Sabbatical Leave application approved.
INVITED CONFERENCE PLENARY: *Community Mental Health Nurses and the Care and Support of People on Conditional Discharge* Taking Risks: Challenges and Rewards in Forensic Rehabilitation. North London Forensic Service - IXth International Conference Cambridge
- November 2006 – May 2007 Listening to recordings, reading transcripts and conducting open coding of interview transcripts
Agreed draft writing plan.
- January 2007 Presented 'Sensitivities' paper to South Wales Mental Health Nursing Journal Club
Presented selected transcript analyses at Friday discourse group.
- April 2007 Presentation to Friday discourse group on Narrative Analysis with Faye Kinsella.
- May 2007 Completed coding and data reduction on service-user transcripts.
First draft of methods chapter completed and submitted to supervisor.
- July 2007 Draft literature review completed and submitted to supervisor.
- August 2007 Annual report to NHS R&D committee.
- September-December 2007 3 month sabbatical commenced. Four substantive data chapters completed and submitted to supervisor

Appendix 1: Organisation and Sequencing

January 2008- June 2008	Attend to revisions and new drafts of data chapters. Second internal supervisor appointed. Draft of Introduction, Discussion and Conclusion chapters completed. Meeting with supervisors to plan for submission.
July 2008	Final revisions and proof-reading of thesis.
August 2008	Full read-through and checking of references. Annual report to NHS R&D committee.
September 2008	Final read-through. Submission of completed thesis

APPENDIX 2: PUBLICATIONS

PUBLICATIONS AND CONFERENCE PRESENTATIONS

Throughout the period of study for this thesis I have had the opportunity to publish some background work related to this field of practice and to present my ideas and ongoing deliberations at international, national and local research conferences and seminars. These are listed below.

PEER REVIEWED PAPERS

(2005) Coffey, M. and Hannigan, B. Community mental health in the UK: restructuring for the 21st Century. *Sociale Psychiatrie*. 24(75): 25-30.

(2006) Coffey, M. Researching service-user views of forensic mental health services: a literature review. *Journal of Forensic Psychiatry and Psychology*. 17(1): 73-107.

CHAPTERS IN EDITED TEXTS

Coffey, M. (2003) Working with mentally disordered offenders Chapter in Hannigan, B. and Coffey, M. (editors) (2003) *The Handbook of Community Mental Health Nursing*. London. Routledge.

Coffey, M and Hannigan, B. (2003) Education and training for community mental health nurses Chapter in Hannigan, B. and Coffey, M. (editors) (2003) *The Handbook of Community Mental Health Nursing*. London. Routledge.

Coffey, M. (2005) Forensic Mental Health in Tummey, R. (ed) *'Planning Care in Mental Health Nursing'* pp.244-259. Basingstoke. Palgrave

Coffey, M. (2006) Community Interventions in *Forensic Mental Health Nursing: Interventions with People with 'Personality Disorder'* (Edited by National Forensic Nurses' Research and Development Group) pp.123-134. Salisbury. Quay Books.

Coffey, M., Morgan, J. and Gronow, T. (2007) Forensic Aspects of Discharge Planning from Acute Care: Transition to Community in *Forensic Mental Health Nursing: Forensic Aspects of Acute Care*.pp.175-185. Salisbury. Quay Books.

Coffey, M. and Jones, R. (Forthcoming 2008) Forensic community mental health nursing in Kettles, A., Woods, P. Byrt, R., Addo, M., Coffey, M. and Doyle, M. (editors) *Forensic Mental Health Nursing*: Salisbury. Quay Books.

CONFERENCE AND RESEARCH SEMINAR PRESENTATIONS

Coffey, M. (2003) "*Forensic Mental Health Nursing in the community and diversion: Towards developing stakeholder informed services*" Invited Keynote. Japanese Mental Health Nursing conference Osaka 27th April 2003.

Coffey, M. (2003) "*Forensic Mental Health Nursing in the community and diversion: Towards developing stakeholder informed services*" Invited Keynote. Japanese Mental Health Nursing conference Tokyo 29th April 2003.

Coffey, M. (2004) "*Narratives of Conditional Community Discharge from Forensic Service Stakeholders*". Presented at the 4th Annual Conference of the International Association of Forensic Mental Health Services. Stockholm June 6th- 9th 2004.

Coffey, M. and Hannigan, B. (2004) "*Community Mental Health Nursing in Wales: An overview of policy, practice, education and research*". Invited conference workshop to the 25th Jubilee Congress of the Dutch Union of Social Psychiatric Nurses (NVSPV). 9th and 10th December 2004. VU University Amsterdam

Coffey, M. and Hannigan, B. (2004) "*Community Mental Health in the UK: Restructuring for the 21st Century*". Invited conference plenary to the 25th Jubilee Congress of the Dutch Union of Social Psychiatric Nurses (NVSPV). 9th and 10th December 2004. VU University Amsterdam

Coffey, M. (2006) "*Researching Forensic Mental Health Populations: Sensitive Topics in a Hard to Reach Group*". Invited Research Seminar BSA Medical Sociology Wales Study Group. Wednesday 12 April 2006. Vivian building, Swansea University

Coffey, M. (2006) "*Community Mental Health Nurses and the Care and Support of People on Conditional Discharge*" Invited plenary Taking Risks: Challenges and Rewards in Forensic Rehabilitation. North London Forensic Service - IXth International Conference 28th September 2006, Gonville and Caius College, Cambridge

Coffey, M. (2007) "*Forensic Mental Health: A Socially Sensitive Topic?*". 22nd January 2007. South Wales Mental Health Nursing Journal Club. Whitchurch Hospital, Cardiff.

Coffey, M. (2007) *Transition and identity: Conditional discharge stories*. Meeting of Mental Health Nurse Academics UK, 12th June 2007 School of Health Science, Swansea University.

Coffey, M. (2008) *Transition and identity: Conditional discharge stories*. Meeting of South Wales Mental Health Nursing Journal Club. 7th February 2008. School of Health Science, Swansea University.

APPENDIX 3: REVIEW TABLE

Updated and revised (in 2008) summary of findings of studies included in review paper (Coffey 2006b).

Author	Sample type	Sample size	Data collection	Data Analysis	Study findings	Rigour
Arrigo, 2001	Mentally ill offenders in the US	n=3	Participant observation as part of ethnographic method	Case study analysis based upon constitutive theory	Multiple findings presented in relation to 3 case studies leading to a theory of transcarceration – a process by which people are alternately and repeatedly contained in the mental health and criminal justice systems. The discourse of disease and dangerousness were implicated in this process.	Sampling procedure not specified. Ethical approval not specified. Contextualised situated extracts of interviews reported. Limitations discussed. No attempt to discuss negative cases.
Brodey et al, 2000	Forensic patients in US urban jail	n=43	20 patients evaluated in person and 23 remotely to compare satisfaction with interview. Group Health Association of America Consumer Satisfaction Survey used.	Descriptive statistics presented and Two way analysis of variance to evaluate differences	Two groups rated the psychiatric evaluation almost identically. The in-person group rated the psychiatrist explanation better than the remote group though this difference was not statistically significant	Sampling procedure not specified. Ethical approval not specified. Standardised measures were generic and not designed for the research population or to be administered in this way. Some limitations discussed.
Byrt and Reece, 1999	inpatients who self-harmed within a English medium secure unit	n=19	Semi-structured interviews	Closed questions analysed by frequency counts. Open questions analysed by identifying themes	The physical and social nature of the medium secure environment did not contribute to self-harm although some participants described feelings of powerlessness in this environment. Nurses are reported to be helpful in allowing expressions of feelings and providing support and understanding. Respondents also report examples of goading by staff.	Sampling procedure not specified. Local research ethics approval. Data analysis not described in detail. Extracts of respondent views included. Limitations discussed. Reflexivity discussed. No negative cases explored.

Author	Sample type	Sample size	Data collection	Data Analysis	Study findings	Rigour
Dell and Grounds 1995	patients on conditional discharge orders (Section 41 Mental Health Act 1983) in UK drawn from Home Office files.	n=46	Structured interview study secondary to a record based study	No method of data analysis described. Responses grouped in regard to structured interview questions	Conditional discharge orders were viewed positively although a third of respondents indicated that the order should ease off with time. Responses indicated that support was necessary in the initial stages following discharge until social networks are established. Service-users reported both positive aspects to the order for example, "it acts as a safe-guard for me" (p.66) and negative aspects, "it becomes a hindrance" (p.67)	Ethical approval not specified. Informed consent achieved. Non-representative sample Short extracts on interviews used to illustrate responses to structured schedule. Context of accounts not described. Some limitations discussed. No negative cases explored.
Ford et al, 1999	Inpatients on an English medium secure unit	n=37	Semi-structured interview schedule designed by the researchers	Scoring of questions using likert scale. No further analysis detailed	Respondents found nurses helpful to talk to and wanted more time to do this. Where respondents were aware of their care plans (only 60%) half found these helpful. The main area of dissatisfaction expressed was limited physical space. Female patients expressed concerns in regard to the provision of male orientated activities.	Local ethics committee permission sought. Data analysis not described. Short extracts of respondent views included. Context of accounts not described. No negative cases explored.
Gerber et al, 2003	Forensic patients living in a Canadian community meeting study criteria of being in community >6months and on Disposition Order	n=15	Standardised measures administered by interview	Scoring of standardised measures. Means compared with those in studies of general psychiatric patient samples.	Respondents felt a sense of belonging in their homes but were not well integrated into the communities where they lived. Respondents report being satisfied with the quality and quantity of their social contacts. Coping skills were found to be similar to other people with psychiatric disabilities.	Ethical approval not specified. Informed consent achieved. Descriptive statistics only. Sample size insufficiently powered to enable more in-depth statistical analysis. Limitations discussed.

Appendix 3 continued

Author	Sample type	Sample size	Data collection	Data Analysis	Study findings	Rigour
Goodwin, 1994	Male and female special hospital patients in England	n=31	self-assessment questionnaire	Frequency count of likert scale responses	80% intend seeking employment on discharge. 70% felt they had suitable skills. 32% wanted additional activities providing in hospital. 23% of male and 22% of female respondents identified deficit areas not addressed.	Ethical approval not specified. Informed consent sought. Sampling procedure not described. Data analysis not described. No extracts of service-user views provided. No negative cases explored.
Hamilton Russell and McGregor Kettles, 1996	inpatients and previous inpatients of a closed forensic ward, an intensive care ward and an open forensic ward in UK	n=29	Survey using self-report questionnaire	Thematic analysis and Friedman two-way analysis of variance	An emphasis on staff spending more time interacting with service-users, a need for improved communication between staff and service-users and a need for regular meetings between allocated nurses and service-users. A lack of preparation for returning to community living was identified. Concerns centred on how service-users would fit in once back in the community, how they would get company and issues related to accommodation, neighbours, benefits and bills.	Ethical approval not specified. Sampling procedure not described. Service-users consulted in drafting of questionnaire. Thematic analysis not described. No extracts of service-user views provided. Limitations discussed. No negative cases explored.
Heyman et al, 2004	Cases study of inpatients and staff on a RSU in UK	n=10	Interviews, observation of case conferences	Thematic analysis of interview transcripts	Ideal-typical risk escalator was reviewed in terms of organisational processes, patient perspectives on risk management and multi-professional collaboration. The RSU needs to be considered as the community in which patients spend most of their time and as such quality of life depends on the availability of social support. The tension between caring for people in groups and individual risk assessment needs to carefully considered.	Local Research Ethics Committee approval achieved. Information sheets and signed informed consent achieved. Extracts of interviews used.

Appendix 3 continued

Author	Sample type	Sample size	Data collection	Data Analysis	Study findings	Rigour
Hinsby and Baker 2004	Inpatients and nurses on RSU	n=4 in each group	Semi-structured interview	Grounded theory and discursive analysis	A core category of 'control' with 5 constituent themes was derived from the data of reciprocal accounts of staff and service-users. Service-users report being able to control their behaviour but occasionally reacting violently due to excess environmental stress. Service-users saw themselves as responsible and rational and institutional control was perceived as punitive.	Ethical approval not specified. Consent obtained and interviews audio recorded. Sampling purposive and convenient. Data analysis detailed. Interview extracts used to support themes. No negative cases explored. Theoretical development absent.
Huckle 1997	Inpatients of forensic medium secure service in Wales	n=15	Standard measures as Morrison et al (1996)	Method of data analysis not described	Respondents reported improvements in level of activities, quality of the food, privacy, noise levels and understanding of the parole system. Dissatisfaction with availability of staff for parole remained an issue. Some respondents expressed a desire for staff to spend more time talking with service-users.	Ethical approval not specified. All in-patients sampled. Response rate 45.5%. Data analysis not described. Frequencies of responses to questionnaire only reported. No negative cases explored.
Morrison et al, 1996	Convenience sample of inpatients of forensic medium secure unit in Wales	n=6	Maudsley Inpatient Satisfaction Schedule. Researcher designed survey questionnaire. Semi-structured interview	Scoring of standardised measures. Content analysis of interview data.	Service-users were most satisfied with the attitudes of nursing staff and occupational therapists. They were least satisfied with staffing levels in relation to supervised leave and complained of boredom and restrictions on their liberty. Uncertainty surrounding supervised leave and how the system worked was also expressed.	Ethical approval not specified. Convenience sample. Response rate 75% on standardised measures. Structure and content of interview not described. Interviews audio recorded and transcribed. Extracts of interviews provided. Context of accounts not described. Data analysis not described. No negative cases explored.

Appendix 3 continued

Author	Sample type	Sample size	Data collection	Data Analysis	Study findings	Rigour
Quinsey et al, 1996	Male offenders in a Canadian secure psychiatric setting and matched non-offender controls	n=60	Each offender given a series of attributional scales to complete in relation to their own index offence. All respondents were then given 8 case histories to rate.	Responses were compared with a matched non-offender sample given similar histories to rate. ANOVA and <i>t</i> tests	Offenders tended to rate other offenders' crimes as less stable and others' likelihood of re-offending as lower than did non-offenders. Offenders saw themselves as less likely to re-offend than their matched non-offender controls rated them. Offenders who saw themselves as less likely to re-offend were consequently less interested in treatment to reduce their re-offending and perhaps therefore more likely to re-offend.	Ethical approval not specified. Limited detail of sample recruitment. Hypothesis provided. Reliability and validity of measures not presented. Inferential statistics demonstrated some statistically significant results.
Rees and Water, 2003	Detained men in medium secure hospital in UK	n=5	Semi-structured interviews	Unspecified qualitative analysis	Service-users report that having leave relieved boredom and gave them hope of eventually moving on from hospital. Unpredictable and last minute changes to leave frustrated service-users who found this difficult to cope with. 'Behaving yourself' and 'doing as you are told' were recognised strategies for gaining staff trust to then facilitate leave. The perception of service-users was that mental health was seldom stated as a reason for gaining leave entitlement.	Ethical committee approval gained. Interview schedule included. Convenience sample. Interviews audio recorded and transcribed. Data analysis not detailed. Short decontextualised extracts used. Limitations discussed No negative cases explored.
Riordan et al, 2002	conditionally-discharged patients (Section 41 Mental Health Act 1983) supervised by English RSU team	n=24	semi-structured interview questionnaire	Unspecified "qualitative approach" (p.121)	Service-users valued the support afforded them on discharge and the reassurance of readmission if needed. Voluntary agency support added an extra level of assistance. Concerns about the disempowering nature of the restrictions and the need for negotiation not coercion highlighted. Concerns expressed about medication and side effects prompting stigma.	Ethical approval not specified. Convenience sample. Short decontextualised interview extracts used. Method of data analysis not described. Limitations discussed No negative cases explored.

Appendix 3 continued

Author	Sample type	Sample size	Data collection	Data Analysis	Study findings	Rigour
Robinson and Collins, 1995	special hospital patients in England	n=79	Survey	Content analysis	94% of respondents were aware of the presence of the council. 53% responded positively to the work of the council although there was some suspicion as to its motives. Service-users used the opportunity to report personal grievances	Ethical approval not specified. Short decontextualised extracts used. Service-user involved in research process. Sampling was opportunistic. Data analysis not described No negative cases explored
Ryan et al, 2002	people with personality disorder diagnoses detained in one special hospital in England	n=61	semi-structured interview	Content analysis, second researcher blind to the objectives of the study categorised a random 10% sample of schedule into the themes identified by main researcher achieving 70% inter-rater reliability. Frequencies and associations analysed.	Half the sample expressed a preference for a high secure setting, 20% for prison and 25% elsewhere, primarily medium secure settings. Most important attribute of staff was considered to be capacity for caring and understanding. An ideal treatment service was considered to be small domestic living units with group and individual therapies.	Hospital ethics committee approval. Sample of total population who met study criteria. Responses documented but not audio recorded during interview. Content analysis is not described. Short extracts of views included. Limitations discussed. No negative cases explored

Author	Sample type	Sample size	Data collection	Data Analysis	Study findings	Rigour
Sainsbury, et al, 2004	In-patients on forensic personality disorder unit in English high secure hospital	n=6	Semi structured interview	Content analysis based on grounded theory	Preliminary categories were identified across the data, including: support, treatment, safety, external belief, belonging, internal motivation and therapeutic relationship. These initial interpersonal categories indicate possible ways of working with people with personality disorder.	Research Ethics committee approval. Purposive sampling. Interviews audio recorded and transcribed. Data analysis described. Extracts of interviews included. Some limitations acknowledged. No negative cases explored.
Schafer and Petermeijer-Taylor, 2003	Male forensic patients in a Canadian federal correctional institution.	n=12	Semi structured interview protocol conducted on 3 occasions	Constant comparative data analysis	Reported difficulties in adjusting to therapeutic regimes, concerns about the differing roles adopted by staff, e.g. rule enforcer and primary therapist, and anxieties about consequences of transgressing boundaries particularly in terms of gender relations. Helpful therapeutic factors included, being listened to, receiving specific feedback, being involved in care planning and the primary therapist being genuinely interested in helping. Therapists characterised as being both supportive and challenging provided a safe and helpful therapeutic environment.	Research and Ethics committee approval. Maximum variation purposive sampling. Participants may not have had a diagnosed mental health problem. Interviews audio recorded and transcribed. Data analysis described. Extracts of interviews included. Theory developments discussed. Limitations discussed. No negative cases explored
Sequeira and Halstead, 2002	Male and female in-patients of an English secure hospital with recent experience of being restrained	n=14	semi-structured interview schedule	aspects of grounded theory, phenomenology and thematic content analysis	Five major themes representative of the persons' experience of restraint; anger, anxiety, mental upset, containment and release of feelings. The behaviour of professionals during the restraining procedure appears particularly important, as service-users report feeling angry at staff who carry on conversations and laugh during the restraint. Restraint can evoke memories of previous trauma leading to further anger and anxiety. Some reported feelings of containment and comfort in being restrained.	Ethics committee approval not specified. Sampling procedure not described. Interviews audio recorded and transcribed. Multiple qualitative approaches to data collection and analysis. Decontextualised extracts reported. Theoretical development absent. Limitations discussed. No negative cases explored.

Author	Sample type	Sample size	Data collection	Data Analysis	Study findings	Rigour
Skelly 1994a	Male special hospital patients readmitted following failed attempt at move to medium secure services in England	n=14	Semi-structured interviews	Grounded theory approach	Two categories are reported in this paper. Service-users initially viewed the move to medium security as a stepping stone to a return to the community however ultimately this was experienced as a backward step. Respondents reported a loss of privileges hard won and greater security than they had been subjected to in the high secure hospital. Reasons for readmission included inappropriate sexual behaviour, absconding and deterioration in mental state.	Ethics committee approval not specified. Sampling procedure not described. Interviews were audio recorded and transcribed. Method of data analysis using a "less rigorous variant of the constant comparative method" (p.171) is not described. Extracts of interviews included. Theoretical development absent. No negative cases explored
Skelly 1994b	Same study as Skelly 1994a	Same study as Skelly 1994a	Same study as Skelly 1994a	Same study as Skelly 1994a	Five categories generated from analysis of data. One category, <i>Playing the Game</i> is reported in this paper. Respondents report a pervasive feeling of threat while in medium secure services that they would be returned to high security should their behaviour be regarded as inappropriate. Lack of formal work activity in medium services left respondents with more time on their hands which in some cases decreased self-esteem. A theory of failure is proposed largely resulting from missed opportunities to provide adequate information and preparation for transfer by professionals	Ethics committee approval not specified. Theoretical sampling used but procedure not described. Data analysis described. Extracts of interviews used to support category system. Theorises from findings. Limitations of the proposed theory are offered. No negative cases explored

Appendix 3 continued

Author	Sample type	Sample size	Data collection	Data Analysis	Study findings	Rigour
Vaughan and Stevenson, 2002	Random selection of male remand and sentenced mentally disordered service-user prisoners in England	n=50	semi-structured interview schedule and medical record review	Scoring of questions using likert scale.	Respondents indicated general satisfaction with mental health provision. Where dissatisfaction was identified this was related to professionals who appeared disinterested, did not listen and offered little help other than medication.	Ethics committee approval not specified. Written consent obtained from participants. Randomisation of sample. Quantitative analysis limited to descriptive statistics. Short interview extracts used. No further analysis detailed. Limitations recognised. No negative cases explored
Vollm et al, 2006	Sample of people who had changed their names in one high secure forensic hospital in England	n=38	Semi-structured interview and socio-demographics from Special Hospitals Case Register	Content analysis interviews using QSR NUD*IST and statistical analysis of socio-demographics using SPSS	31 people who had made names changes only once or twice shared common reasons e.g. making or breaking family ties, wanting a fresh start, and difficulties with the name itself. While multiple changers had more idiosyncratic or 'bizarre' reasons and achieved little satisfaction with these changes.	Research Ethics committee approval. Interviews were audio recorded and transcribed. Data analysis emphasises computer package rather than theoretical approach. Decontextualised interview extracts used. Limitations discussed.
Walker and Gudjonsson, 2000	Cross sectional study of medium secure, high secure recently admitted and high secure pre-discharge forensic patients in England	n=58	Clinician administered Lancashire Quality of Life Profile (LQOLP).	Scoring of LQOLP and <i>t</i> -tests to compare published norms with those found in study	No significant difference in overall quality of life between detained forensic patients and outpatients in general services. Detained patients had significantly worse quality of life ratings including: living situation (including living arrangements, independence, control and privacy); legal and safety; and health. Detained patients rated their social relations as significantly better than their non-detained counterparts.	Ethics committee approval not specified. Sample selected from diverse settings. Hypothesis provided. Reliability and validity of measure with this group not tested. Cross sectional design and sample size and selection limited generalisability. These limitations are discussed.

APPENDIX 4: INFORMATION SHEETS FOR PARTICIPANTS

INFORMATION SHEET – Service-user – SETTING ONE

Personal Experiences of Conditional Discharge

I am interviewing mental health service-users in South Wales to improve our understanding of the process of discharge from hospital.

People who are conditionally-discharged from hospital have a range of positive and negative experiences. Some people find it hard to re-settle in the community while others find it less difficult. Professionals who work with people who are conditionally-discharged need to learn more about the experience from both the service-users' perspective and the views of family members who support you. This information will be used to inform the way that professionals work. I am also interviewing nurses and social workers to get their views.

I would like to invite you to take part in this study. Your psychiatric consultant has given me permission to approach you, but it is entirely up to you whether or not to take part. I will only interview you with your permission and you can withdraw at any time.

The interviews will be audio-taped and typed up so that I don't miss anything you say. If you like, you can have a copy of the interview so that you have a chance to let me know if I have misunderstood anything you have said. Once the interview is typed up, the tapes will be destroyed. Everything you tell me will be kept in confidence, your name will not be used in typing up the interviews and you will not be identified in the final report.

This study is not part of your routine treatment and if you decide that you are not able to help me then this will not have any bearing upon your treatment and no one else will know that you have decided against participating.

Results of the study will be written up in a report which will be submitted as part of my PhD thesis. I will also submit parts of the research for publication in professional journals but I will ensure that your confidentiality is maintained in this process.

Everyone who feels able to take part in the study will be given a summary copy of the results.

I would like to contact you within the next 2 weeks to see if you are willing to take part. If so I will arrange a time and place suitable to you. You can be interviewed at home or at the resource centre and you can have someone with you during the interview if you wish. The interview will take between 30-60 minutes. You will be asked to tell your story with particular emphasis on your discharge and return to the community.

The research is being carried out by Michael Coffey, a Nurse Lecturer from the University of Wales Swansea, and is supervised by Prof. David Hughes at Swansea.

This information sheet is yours to keep. If you have any further questions or if anything is unclear about this research you can contact **Michael Coffey on 01792 518521** (during working hours only) and I will be happy to answer your questions.

INFORMATION SHEET – FCMHN – SETTING ONE

Personal Experiences of Conditional Discharge

I am interviewing Forensic Community Mental Health Nurses in South Wales to improve our understanding of the process of discharge from hospital. I am interested in your stories of providing support to conditionally-discharged service-users.

Nurses who provide ongoing support and follow-up to conditionally-discharged service-users will have a range of positive and negative experiences. Helping people to resettle and re-establish themselves in the community can be challenging work. I am interested to hear about your experiences of offering care and the role if any conditional discharge may play in the process. This information will be used to inform professional practice developments. I am also interviewing social workers, service-users and family members to get their views.

I would like to invite you to take part in this study. The research has been approved by the Local Research Ethics Committee. I will only interview you with your permission and you can withdraw at any time. The interviews will be audio-taped and typed up so that I don't miss anything you say. If you like, you can have a copy of the interview so that you have a chance to let me know if I have misunderstood anything you have said. Once the interview is typed up, the tapes will be destroyed. Everything you tell me will be kept in confidence, your name will not be used in typing up the interviews and you will not be identified in the final report. This study is not part of your contract of employment and if you decide that you are not able to help me then this will not have any bearing upon your working conditions and no one else will know that you have decided this.

Results of the study will be written up in a report which will be submitted as part of my PhD thesis. I will also submit parts of the research for publication in professional journals. I will ensure that your confidentiality is maintained in this process.

The research is being carried out by a Nurse Lecturer from the University of Wales Swansea, Michael Coffey and is supervised by Prof. David Hughes at Swansea.

Everyone who feels able to take part in the study will be given a summary copy of the results.

I would like to contact you within the next 2 weeks to see if you are willing to take part. If so I will arrange a time and place suitable to you. You can be interviewed at work or at a convenient alternative for you. The interview will take between 30-60 minutes. You will be asked to tell your story with particular emphasis on your role in supporting service-users on their discharge and return to the community.

This information sheet is yours to keep. If you have any further questions or if anything is unclear about this research you can contact **Michael Coffey on 01792 518521** (during working hours only) and I will be happy to answer your questions.

INFORMATION SHEET – Approved Social Workers – SETTING ONE

Personal Experiences of Conditional Discharge

I am interviewing Approved Social Workers in South Wales to improve our understanding of the process of discharge from hospital. I am interested in your stories of providing support to conditionally-discharged service-users.

Social workers who provide ongoing support and follow-up to conditionally-discharged service-users will have a range of positive and negative experiences. Helping people to resettle and re-establish themselves in the community can be challenging work. I am interested to hear about your experiences of offering care and the role if any conditional discharge may play in the process. This information will be used to inform professional practice developments. I am also interviewing forensic community mental health nurses, service-users and family members to get their views.

I would like to invite you to take part in this study. The research has been approved by the Local Research Ethics Committee. I will only interview you with your permission and you can withdraw at any time. The interviews will be audio-taped and typed up so that I don't miss anything you say. If you like, you can have a copy of the interview so that you have a chance to let me know if I have misunderstood anything you have said. Once the interview is typed up, the tapes will be destroyed. Everything you tell me will be kept in confidence, your name will not be used in typing up the interviews and you will not be identified in the final report. This study is not part of your contract of employment and if you decide that you are not able to help me then this will not have any bearing upon your working conditions and no one else will know that you have decided this.

Results of the study will be written up in a report which will be submitted as part of my PhD thesis. I will also submit parts of the research for publication in professional journals. I will ensure that your confidentiality is maintained in this process.

The research is being carried out by a Nurse Lecturer from the University of Wales Swansea, Michael Coffey and is supervised by Prof. David Hughes at Swansea.

Everyone who feels able to take part in the study will be given a summary copy of the results.

I would like to contact you within the next 2 weeks to see if you are willing to take part. If so I will arrange a time and place suitable to you. You can be interviewed at work or at a convenient alternative for you. The interview will take between 30-60 minutes. You will be asked to tell your story with particular emphasis on your role in supporting service-users on their discharge and return to the community.

This information sheet is yours to keep. If you have any further questions or if anything is unclear about this research you can contact **Michael Coffey on 01792 518521** (during working hours only) and I will be happy to answer your questions.

INFORMATION SHEET – Service-user – SETTING TWO

Personal Experiences of Conditional Discharge

I would like to invite you to take part in this study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please read the following information carefully and discuss it with others if you wish. Take time to decide whether or not you wish to take part.

I am interviewing mental health service-users in South Wales to improve our understanding of the process of discharge from hospital. People who are conditionally-discharged from hospital have a range of positive and negative experiences. Some people find it hard to re-settle in the community while others find it less difficult. Professionals who work with people who are conditionally-discharged need to learn more about the experience from both the service-users' perspective and the views of those who support you. This information will be used to inform the way that professionals work. I am also interviewing nurses and social workers to get their views.

If you decide to participate in the study I will ask your consultant for permission to interview you. I will then only interview you with your permission and you can withdraw at any time. With your permission your GP will be notified of your participation in the study. This study is not part of your routine treatment and if you decide that you are not able to help me then this will not have any bearing upon your treatment and no one else will know this.

I would also like to interview a family member, carer, friend or a significant other identified by you for this research. I will only do this with your permission and if you or they decide they would rather not be interviewed then this will not exclude you from participating.

The interviews will be audio-taped and typed up so that I don't miss anything you say. If you like, you can have a copy of the interview so that you have a chance to let me know if I have misunderstood anything you have said. This may involve a second interview with me to give you the chance to add anything further to your story. Once the interview is typed up, the tapes will be destroyed. Everything you tell me will be kept in confidence, your name will not be used in typing up the interviews and you will not be identified in the final report.

Results of the study will be written up in a report which will be submitted as part of my PhD thesis. I will also submit parts of the research for publication in professional journals but I will ensure that your confidentiality is maintained in this process. Everyone who feels able to take part in the study will be given a summary copy of the results.

I would like to contact you within the next 2 weeks to see if you are willing to take part. If so I will arrange a time and place suitable to you. You can be interviewed at home or somewhere else convenient for you and you can have someone with you during the interview if you wish. The interview will take between 30-60 minutes. You will be asked to tell your story with particular emphasis on your discharge and return to the community.

The research is being carried out by Michael Coffey, a Nurse Lecturer from the University of Wales Swansea, and is supervised by Prof. David Hughes at the School of Health Science, University of Wales Swansea.

This information sheet is yours to keep. If you have any further questions or if anything is unclear about this research you can contact me, **Michael Coffey on 01792 518521** (during working hours only) and I will be happy to answer your questions.

INFORMATION SHEET – FCMHN –SETTING TWO

Personal Experiences of Conditional Discharge

I would like to invite you to take part in this study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please read the following information carefully and discuss it with others if you wish. Take time to decide whether or not you wish to take part.

I am interviewing Forensic Community Mental Health Nurses in South Wales to improve our understanding of the process of discharge from hospital. I am interested in your stories of providing support to conditionally-discharged service-users. Nurses who provide ongoing support and follow-up to conditionally-discharged service-users will have a range of positive and negative experiences. Helping people to resettle and re-establish themselves in the community can be challenging work. I am interested to hear about your experiences of offering care and the role if any conditional discharge may play in the process. This information will be used to inform professional practice developments. I am also interviewing social workers, service-users and family/friend/carer/significant others of the person to get their views.

The research has been approved by the Local Research Ethics Committee. I will only interview you with your permission and you can withdraw at any time. The interviews will be audio-taped and typed up so that I don't miss anything you say. If you like, you can have a copy of the interview so that you have a chance to let me know if I have misunderstood anything you have said. This may involve a second interview with me to give you the chance to add anything further to your story. Once the interview is typed up, the tapes will be destroyed. Everything you tell me will be kept in confidence, your name will not be used in typing up the interviews and you will not be identified in the final report. This study is not part of your contract of employment and if you decide that you are not able to help me then this will not have any bearing upon your working conditions and no-one else will know that you have decided this.

Results of the study will be written up in a report which will be submitted as part of my PhD thesis. I will also submit parts of the research for publication in professional journals. I will ensure that your confidentiality is maintained in this process.

The research is being carried out by a Nurse Lecturer from the University of Wales Swansea, Michael Coffey and is supervised by Prof. David Hughes at the School of Health Science, University of Wales Swansea. Everyone who feels able to take part in the study will be given a summary copy of the results.

I would like to contact you within the next 2 weeks to see if you are willing to take part. If so I will arrange a time and place suitable to you. You can be interviewed at work or at a convenient alternative for you. The interview will take between 30-60 minutes. You will be asked to tell your story with particular emphasis on your role in supporting service-users on their discharge and return to the community. This information sheet is yours to keep. If you have any further questions or if anything is unclear about this research you can contact me, **Michael Coffey on 01792 518521** (during working hours only) and I will be happy to answer your questions.

INFORMATION SHEET – Approved Social Workers – SETTING TWO

Personal Experiences of Conditional Discharge

I would like to invite you to take part in this study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please read the following information carefully and discuss it with others if you wish. Take time to decide whether or not you wish to take part.

I am interviewing Approved Social Workers in South Wales to improve our understanding of the process of discharge from hospital. I am interested in your stories of providing support to conditionally-discharged service-users. Social workers who provide ongoing support and follow-up to conditionally-discharged service-users will have a range of positive and negative experiences. Helping people to resettle and re-establish themselves in the community can be challenging work. I am interested to hear about your experiences of offering care and the role if any conditional discharge may play in the process. This information will be used to inform professional practice developments. I am also interviewing forensic community mental health nurses, service-users and family/friend/carer/significant others to get their views.

The research has been approved by the Local Research Ethics Committee. I will only interview you with your permission and you can withdraw at any time. The interviews will be audio-taped and typed up so that I don't miss anything you say. If you like, you can have a copy of the interview so that you have a chance to let me know if I have misunderstood anything you have said. This may involve a second interview with me to give you the chance to add anything further to your story. Once the interview is typed up, the tapes will be destroyed. Everything you tell me will be kept in confidence, your name will not be used in typing up the interviews and you will not be identified in the final report. This study is not part of your contract of employment and if you decide that you are not able to help me then this will not have any bearing upon your working conditions and no one else will know that you have decided this.

Results of the study will be written up in a report which will be submitted as part of my PhD thesis. I will also submit parts of the research for publication in professional journals. I will ensure that your confidentiality is maintained in this process.

The research is being carried out by a Nurse Lecturer from the University of Wales Swansea, Michael Coffey and is supervised by Prof. David Hughes at the School of Health Science, University of Wales Swansea. Everyone who feels able to take part in the study will be given a summary copy of the results.

I would like to contact you within the next 2 weeks to see if you are willing to take part. If so I will arrange a time and place suitable to you. You can be interviewed at work or at a convenient alternative for you. The interview will take between 30-60 minutes. You will be asked to tell your story with particular emphasis on your role in supporting service-users on their discharge and return to the community.

This information sheet is yours to keep. If you have any further questions or if anything is unclear about this research you can contact me, **Michael Coffey on 01792 518521** (during working hours only) and I will be happy to answer your questions.

Information Sheet v4 02/03/04 (ASW)

APPENDIX 5: CONSENT FORMS

Consent form Feb2003version1

Consent Form – SETTING ONE

Title of Project: Personal Experiences of Conditional Discharge

Name of Researcher: Michael Coffey

I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions about it.

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.

I understand that I have been invited to take part in this research because I have experiences of conditional discharge. I understand that the interview will take between 30-60 minutes and will be tape-recorded. No-one other than the researcher will have access to the tapes and these will be erased once transcribed by the researcher. I understand that my responses will remain anonymous and will not have any effect upon the treatment that I receive.

I understand that any information I give will be kept confidential with the exception of any information which suggests that either myself or someone else may be at risk of harm. In such circumstances I understand that the researcher will act upon this information in accordance with his professional code of conduct.

I agree to take part in the above study.

Date

Subjects signature

Name in block capitals.....

Researchers signature.....

Michael Coffey School of Health Science UWS Telephone 01792 518521

Consent Form – SETTING TWO

Title of Project: Personal Experiences of Conditional Discharge

Name of Researcher: Michael Coffey

I confirm that I have read and understand the information sheet (version 4 02/03/04) for the above study. I have had the opportunity to ask Michael Coffey questions about the study and have received a satisfactory explanation.

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and without my medical care or legal rights being affected. I further understand that details of my participation up to the time of withdrawal may be stored anonymously on file and may be used in the final analysis of data.

I understand that I have been invited to take part in this research because I have experiences of conditional discharge. I understand that the interview will take between 30-60 minutes and will be tape-recorded. No-one other than the researcher will have access to the tapes and these will be erased once transcribed by the researcher. I understand that my responses will remain anonymous and will not have any effect upon the treatment that I receive.

I understand that any information I give will be kept confidential with the exception of any information which suggests that either myself or someone else may be at risk of harm. In such circumstances I understand that the researcher will act upon this information in accordance with his professional code of conduct.

I have been asked if my GP can be contacted to inform him/her of my participation in this study. My answer to this is YES NO (please circle one)

I confirm that I have had at least 2 weeks to consider my participation in this study.

I agree to take part in the above study.

Date

Subjects signature

Name in block capitals.....

Researcher's signature.....

Michael Coffey School of Health Science UWS Telephone 01792 518521

APPENDIX 6: INTERVIEW GUIDES

INTERVIEW GUIDE – Service-user – SETTING ONE AND TWO

**School of Health Science
University of Wales Swansea**

Stakeholder Narratives of Conditional Community Discharge

Date & time of interview:

Venue:

Length of time:

Format: Introductions
 Describe project
 Read information sheet
 Explain format of interview
 Read consent form and sign

Demographic information

Topic guide

(How did you come to be here today?)

Community living

How has it been for you living here since you were discharged?

Personal Identity

In what ways has your experiences changed the way you see yourself now?

Social Support

(support networks based upon Grusky et al's 1985 3 forms of social bonding)

Who do you draw on for support?

Tell me about how you get on with your **family**. How has this changed over the years?

Tell me how you have made **friends** since leaving hospital.

What has it been like looking for something to do during the day?

Tell me how you spend a typical day. (**Employment**)

So what happened next? So what happened then?
--

Social Inclusion

(friendships, housing, stigma, discrimination)

What conditions does the restriction order place upon your discharge?

Tell me how you see the restriction order affecting your life.

In what ways do the conditions of your discharge influence your daily life?

How do you explain your past to people? (How do they react to this?)

Can you give me some examples of how people behave towards you?

Social Adjustment

(after Grusky et al 1985)

Personal adjustment – e.g. self care activities

Community adjustment – e.g. frequency of deviant or disruptive behaviour

Professional Supports

How long have you known your CPN?

Tell me about the time you first met.

How often do you see the CPN?

What does the CPN do when you see them?

Appendix 6: Interview Guides

Can you tell me how you see your relationship with your CPN (In what ways would this be different if you were not on a restriction order)

How long have you known your social worker?

Tell about the time you first met them.

How often do you see the social worker?

What does the social worker do when you see them?

Can you tell me how you see your relationship with your Social Worker (In what ways would this be different if you were not on a restriction order)

Being in hospital

What was life like for you in hospital before you were discharged?

Leaving hospital

Please tell me about the story of you leaving hospital and returning to live here in the community. Start with when you first knew you were going to leave hospital, how you made plans for coming out and what it was like when you first left.

What/who has helped you to resettle into the community following your discharge? e.g. what has made it easier, in what ways, what else might have made it easier? Any particular example?

In what ways have you found it difficult to resettle into the community since your discharge? What has been hardest about living back here? Any particular incident?

Looking back now at your discharge from hospital, how has your perception of the community changed? Any examples?

We are nearing the end of the interview is there anything else that you would like to add?

Thank participants for their time and offer reassurance with regard to confidentiality of responses.

INTERVIEW GUIDE – FCMHN & ASW – SETTING ONE AND TWO

**School of Health Science
University of Wales Swansea**

Stakeholder Narratives of Conditional Community Discharge

Date & time of interview:

Venue:

Length of time:

Format: Introductions
 Describe project
 Read information sheet
 Explain format of interview
 Read consent form and sign

Demographic information

Topic guide

Leaving hospital

Please tell me about your experiences of supporting people leaving hospital and returning to live in the community on conditional discharge. Start with when you first meet the person, how you help them make plans for coming out and what it was like when they first left.

What/who helps to resettle people into the community following discharge?
e.g. what has made it easier, in what ways, what else might have made it easier? Any particular example?

In what ways do you find it difficult to resettle people into the community since discharge? Any particular incident?

What influence if any does the restriction order have upon the process of working with people on their discharge? Any examples?

Social Support

(support networks based upon Grusky et al's 1985 3 forms of social bonding)

Tell me about your experiences of helping service-users on restriction orders to access social support

family

friends

Employment

Social Inclusion

(friendships, housing, stigma, discrimination)

In what ways do you see restriction orders helping service-users to re-integrate into the community? Any examples?

In what ways do you see the restriction order preventing service-users re-integrating into the community? Any examples?

Social Adjustment

(after Grusky et al 1985)

Please tell me about your experiences of helping service-users on restriction orders in their adjustments to living in the community again.

Personal adjustment – e.g. self care activities

Community adjustment – e.g. frequency of deviant or disruptive behaviour

How do you see the restriction order helping or hindering this process?

Appendix 6: Interview Guides

Professional Supports

What do you see as your main role in working with service-users' on restriction orders?

Can you tell me how you see your relationship with service-users on restriction orders? (In what ways would this be different if they were not on a restriction order)

How do you see your role in relation to other professionals working with service-users on restriction orders? Any examples that you think illustrate this?

We are nearing the end of the interview is there anything else that you would like to add?

Thank participants for their time and offer reassurance with regard to confidentiality of responses.

APPENDIX 7: OPEN CODES (FREE NODES)

QSR N6 Full version, revision 6.0.
Licensee: School of Health Science.

PROJECT: MDO, User Michael Coffey, 2:19 pm, May 9, 2007.

REPORT ON NODES FROM (F) 'Free Nodes'
Depth: ALL
Restriction on coding data: NONE

(F) //Free Nodes
This node codes 0 documents.

(F 82) //Free Nodes/ - frustrated
This node codes 1 document.

1: SU10

(F 41) //Free Nodes/ - 'things being on top of me'
This node codes 1 document.

1: SU02

(F 20) //Free Nodes/ - fear
This node codes 13 documents.

1: SU01 2: SU03 3: SU05 4: SU07
5: SU07a 6: SU09 7: SU10 8: SU11
9: SU14 10: SU16 11: SU17 12: SU19
13: SU20

(F 34) //Free Nodes/ - feeling dead
This node codes 1 document.

1: SU02

(F 10) //Free Nodes/ - feeling trapped
This node codes 1 document.

1: SU01

(F 29) //Free Nodes/ - hopes
This node codes 4 documents.

1: SU01 2: SU07 3: SU09 4: SU17

Appendix 7:List of Open Codes

```
*****
*****
(F 3) //Free Nodes/ - like a puppet
This node codes 1 document.
1: SU01
*****
*****
(F 4) //Free Nodes/ - positive
This node codes 7 documents.
1: SU01 2: SU06 3: SU08 4: SU10
5: SU17 6: SU18 7: SU19
*****
*****
(F 47) //Free Nodes/ - suicide
This node codes 2 documents.
1: SU02 2: SU12
*****
*****
(F 16) //Free Nodes/ -freedom and confinement
This node codes 6 documents.
1: SU01 2: SU02 3: SU07 4: SU08
5: SU14 6: SU19
*****
*****
(F 17) //Free Nodes/ - humour
This node codes 5 documents.
1: SU01 2: SU02 3: SU04 4: SU12
5: SU17
*****
*****
(F 81) //Free Nodes/ - 'a dangerous person'
This node codes 2 documents.
1: SU08 2: SU09
*****
*****
(F 39) //Free Nodes/ - 'a squeaky clean'
This node codes 1 document.
1: SU02
*****
*****
(F 37) //Free Nodes/ - 'my way of being'
This node codes 1 document.
1: SU02
*****
*****
(F 86) //Free Nodes/ - 'not a thief'
This node codes 1 document.
1: SU20
*****
*****
```

Appendix 7:List of Open Codes

(F 56) //Free Nodes/ - a patient

This node codes 2 documents.

1: SU02 2: SU10

(F 71) //Free Nodes/ - alcohol

This node codes 2 documents.

1: SU04 2: SU09

(F 36) //Free Nodes/ - honest and truthful

This node codes 1 document.

1: SU02

(F 70) //Free Nodes/ - independent

This node codes 3 documents.

1: SU04 2: SU06 3: SU14

(F 83) //Free Nodes/ - intelligent

This node codes 3 documents.

1: SU10 2: SU12 3: SU20

(F 25) //Free Nodes/ - jinxed

This node codes 1 document.

1: SU01

(F 30) //Free Nodes/ - male

This node codes 5 documents.

1: SU01 2: SU02 3: SU13 4: SU18

5: SU20

(F 12) //Free Nodes/ - mental illness

This node codes 15 documents.

1: SU01 2: SU02 3: SU03 4: SU04
5: SU05 6: SU06 7: SU09 8: SU10
9: SU11 10: SU13 11: SU14 12: SU17
13: SU18 14: SU19 15: SU20

(F 52) //Free Nodes/ - murderer

This node codes 2 documents.

1: SU02 2: SU04

(F 22) //Free Nodes/ - normal

Appendix 7:List of Open Codes

This node codes 6 documents.

1: SU01 2: SU06 3: SU08 4: SU09
5: SU10 6: SU19

(F 35) //Free Nodes/ - not a threat

This node codes 2 documents.

1: SU02 2: SU11

(F 60) //Free Nodes/ - not to be messed with

This node codes 4 documents.

1: SU03 2: SU03a 3: SU06 4: SU18

(F 1) //Free Nodes/ - occupation

This node codes 19 documents.

1: SU01 2: SU02 3: SU03 4: SU03a
5: SU04 6: SU05 7: SU06 8: SU07a
9: SU08 10: SU10 11: SU11 12: SU12
13: SU13 14: SU14 15: SU15 16: SU17
17: SU18 18: SU19 19: SU20

(F 79) //Free Nodes/ - place

This node codes 6 documents.

1: SU06 2: SU08 3: SU10 4: SU14
5: SU16 6: SU17

(F 11) //Free Nodes/ - regular things

This node codes 1 document.

1: SU01

(F 32) //Free Nodes/ - respectable

This node codes 2 documents.

1: SU01 2: SU12

(F 26) //Free Nodes/ - social sensitivity

This node codes 18 documents.

1: SU01 2: SU02 3: SU03 4: SU04
5: SU05 6: SU06 7: SU08 8: SU09
9: SU11 10: SU12 11: SU13 12: SU14
13: SU15 14: SU16 15: SU17 16: SU18
17: SU19 18: SU20

(F 84) //Free Nodes/ - worked really hard

Appendix 7:List of Open Codes

This node codes 2 documents.

1: SU10 2: SU14

(F 76) //Free Nodes/ -'I've come down'

This node codes 1 document.

1: SU05

(F 85) //Free Nodes/ -'quite popular'

This node codes 1 document.

1: SU11

(F 73) //Free Nodes/ - aftercare

This node codes 16 documents.

1: SU05 2: SU06 3: SU07 4: SU07a
5: SU08 6: SU09 7: SU11 8: SU12
9: SU13 10: SU14 11: SU15 12: SU16
13: SU17 14: SU18 15: SU19 16: SU20

(F 58) //Free Nodes/ - being out of hospital

This node codes 10 documents.

1: SU03 2: SU04 3: SU06 4: SU09
5: SU10 6: SU12 7: SU13 8: SU14
9: SU16 10: SU20

(F 46) //Free Nodes/ - court

This node codes 4 documents.

1: SU02 2: SU04 3: SU05 4: SU06

(F 33) //Free Nodes/ - entering hospital

This node codes 6 documents.

1: SU01 2: SU04 3: SU05 4: SU06
5: SU17 6: SU18

(F 55) //Free Nodes/ - getting leave

This node codes 4 documents.

1: SU02 2: SU11 3: SU13 4: SU18

(F 77) //Free Nodes/ - hospital to hospital

This node codes 4 documents.

1: SU06 2: SU07 3: SU08 4: SU15

Appendix 7:List of Open Codes

(F 65) //Free Nodes/ - preparing for discharge

This node codes 13 documents.

1: SU04 2: SU05 3: SU07 4: SU08
5: SU10 6: SU11 7: SU12 8: SU13
9: SU14 10: SU17 11: SU18 12: SU19
13: SU20

(F 61) //Free Nodes/ - tribunals

This node codes 13 documents.

1: SU01 2: SU03a 3: SU04 4: SU08
5: SU09 6: SU10 7: SU11 8: SU12
9: SU13 10: SU14 11: SU15 12: SU18
13: SU20

(F 2) //Free Nodes/ -leaving hospital

This node codes 21 documents.

1: SU01 2: SU02 3: SU03 4: SU04
5: SU05 6: SU06 7: SU07 8: SU07a
9: SU08 10: SU09 11: SU10 12: SU11
13: SU12 14: SU13 15: SU14 16: SU15
17: SU16 18: SU17 19: SU18 20: SU19
21: SU20

(F 24) //Free Nodes/ -talk about restriction order

This node codes 20 documents.

1: SU01 2: SU02 3: SU03 4: SU03a
5: SU05 6: SU06 7: SU07 8: SU07a
9: SU08 10: SU09 11: SU10 12: SU11
13: SU12 14: SU13 15: SU14 16: SU16
17: SU17 18: SU18 19: SU19 20: SU20

(F 43) //Free Nodes/ - pets

This node codes 2 documents.

1: SU02 2: SU16

(F 27) //Free Nodes/ - staff

This node codes 18 documents.

1: SU01 2: SU02 3: SU03a 4: SU04
5: SU06 6: SU07 7: SU07a 8: SU08
9: SU09 10: SU10 11: SU11 12: SU12
13: SU13 14: SU15 15: SU16 16: SU17
17: SU19 18: SU20

(F 13) //Free Nodes/ -family

Appendix 7:List of Open Codes

This node codes 19 documents.

1: SU01	2: SU02	3: SU03a	4: SU04
5: SU05	6: SU06	7: SU07a	8: SU08
9: SU09	10: SU10	11: SU11	12: SU13
13: SU14	14: SU15	15: SU16	16: SU17
17: SU18	18: SU19	19: SU20	

(F 15) //Free Nodes/ -friends

This node codes 17 documents.

1: SU01	2: SU02	3: SU03	4: SU03a
5: SU04	6: SU05	7: SU07a	8: SU09
9: SU11	10: SU12	11: SU13	12: SU14
13: SU15	14: SU16	15: SU17	16: SU18
17: SU19			

(F 28) //Free Nodes/ -intimate

This node codes 7 documents.

1: SU01	2: SU05	3: SU07a	4: SU09
5: SU13	6: SU18	7: SU19	

(F 5) //Free Nodes/ -mistrust of staff

This node codes 2 documents.

1: SU01	2: SU16
---------	---------

(F 62) //Free Nodes/ - a double life

This node codes 1 document.

1: SU03a

(F 21) //Free Nodes/ - a typical day

This node codes 10 documents.

1: SU01	2: SU02	3: SU03a	4: SU06
5: SU08	6: SU09	7: SU11	8: SU14
9: SU16	10: SU17		

(F 80) //Free Nodes/ - accommodation

This node codes 10 documents.

1: SU07	2: SU07a	3: SU09	4: SU10
5: SU11	6: SU14	7: SU15	8: SU16
9: SU17	10: SU19		

(F 18) //Free Nodes/ - before hospital

This node codes 5 documents.

1: SU01	2: SU16	3: SU18	4: SU19
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Appendix 7:List of Open Codes

5: SU20

(F 51) //Free Nodes/ - being different to other patients

This node codes 12 documents.

1: SU02 2: SU03 3: SU03a 4: SU05
5: SU06 6: SU10 7: SU11 8: SU12
9: SU13 10: SU14 11: SU18 12: SU20

(F 74) //Free Nodes/ - being ill

This node codes 1 document.

1: SU05

(F 59) //Free Nodes/ - being in hospital

This node codes 15 documents.

1: SU03 2: SU03a 3: SU04 4: SU05
5: SU06 6: SU08 7: SU10 8: SU11
9: SU12 10: SU13 11: SU16 12: SU17
13: SU18 14: SU19 15: SU20

(F 42) //Free Nodes/ - being out of hospital

This node codes 17 documents.

1: SU02 2: SU03 3: SU04 4: SU05
5: SU06 6: SU07 7: SU08 8: SU09
9: SU10 10: SU11 11: SU13 12: SU14
13: SU16 14: SU17 15: SU18 16: SU19
17: SU20

(F 53) //Free Nodes/ - community responses

This node codes 7 documents.

1: SU02 2: SU04 3: SU05 4: SU10
5: SU13 6: SU17 7: SU19

(F 64) //Free Nodes/ - court to hospital

This node codes 4 documents.

1: SU04 2: SU05 3: SU06 4: SU10

(F 14) //Free Nodes/ - discrimination

This node codes 3 documents.

1: SU01 2: SU02 3: SU17

(F 63) //Free Nodes/ - drugs

This node codes 3 documents.

Appendix 7:List of Open Codes

1: SU03a 2: SU10 3: SU14

(F 44) //Free Nodes/ - failures in care
This node codes 11 documents.
1: SU02 2: SU04 3: SU06 4: SU07
5: SU10 6: SU11 7: SU12 8: SU14
9: SU17 10: SU19 11: SU20

(F 19) //Free Nodes/ - fear
This node codes 2 documents.
1: SU01 2: SU08

(F 40) //Free Nodes/ - heroic
This node codes 3 documents.
1: SU02 2: SU06 3: SU10

(F 31) //Free Nodes/ - integration
This node codes 3 documents.
1: SU01 2: SU16 3: SU19

(F 45) //Free Nodes/ - new skills
This node codes 1 document.
1: SU02

(F 6) //Free Nodes/ - of offending
This node codes 13 documents.
1: SU01 2: SU02 3: SU03a 4: SU04
5: SU05 6: SU06 7: SU08 8: SU09
9: SU11 10: SU17 11: SU18 12: SU19
13: SU20

(F 49) //Free Nodes/ - of the victim
This node codes 2 documents.
1: SU02 2: SU04

(F 7) //Free Nodes/ - pillar of the church
This node codes 1 document.
1: SU01

(F 38) //Free Nodes/ - prison to hospital
This node codes 7 documents.

Appendix 7:List of Open Codes

1: SU02 2: SU05 3: SU09 4: SU10
5: SU11 6: SU14 7: SU15

(F 67) //Free Nodes/ - returning to hospital
This node codes 6 documents.
1: SU04 2: SU06 3: SU09 4: SU14
5: SU15 6: SU20

(F 54) //Free Nodes/ - risk
This node codes 5 documents.
1: SU02 2: SU04 3: SU08 4: SU11
5: SU14

(F 66) //Free Nodes/ - serving less time
This node codes 2 documents.
1: SU04 2: SU18

(F 48) //Free Nodes/ - suicide
This node codes 5 documents.
1: SU02 2: SU12 3: SU14 4: SU17
5: SU19

(F 50) //Free Nodes/ - supportive friends
This node codes 1 document.
1: SU02

(F 57) //Free Nodes/ - surveillance
This node codes 13 documents.
1: SU02 2: SU03 3: SU04 4: SU05
5: SU07a 6: SU08 7: SU10 8: SU11
9: SU12 10: SU14 11: SU15 12: SU16
13: SU19

(F 23) //Free Nodes/ - turning point
This node codes 3 documents.
1: SU01 2: SU12 3: SU17

(F 78) //Free Nodes/ - uncertainty
This node codes 9 documents.
1: SU06 2: SU07 3: SU07a 4: SU08
5: SU11 6: SU12 7: SU14 8: SU19
9: SU20

Appendix 7:List of Open Codes

```
*****
*****
(F 9) //Free Nodes/ - being punished
This node codes 1 document.
1: SU01
*****
*****
(F 69) //Free Nodes/story - more mature
This node codes 2 documents.
1: SU04 2: SU11
*****
*****
(F 75) //Free Nodes/story - serving more time
This node codes 3 documents.
1: SU05 2: SU06 3: SU10
*****
*****
(F 68) //Free Nodes/story - speeding
This node codes 1 document.
1: SU04
*****
*****
(F 72) //Free Nodes/story -living with the offence
This node codes 1 document.
1: SU04
*****
*****
(F 8) //Free Nodes/uncertainty - regarding symptoms
This node codes 2 documents.
1: SU01 2: SU05
```

APPENDIX 8: Table of those declining participation

Table showing Known Refusals

Service-User	Reasons
R1Male: Setting 2	Refused by phone- He was very apologetic but felt that "having thought about it a lot" and having received my letter making an appointment that he was "very sorry" and had changed his mind and that "this was not the right time" for him.
R2Male: Setting 2	Social worker reported that he had said "No, I'm not interested, I don't want to talk about it"
R3Male: Setting 2	Refused to social worker– no other information offered
R4Male: Setting 1	Said no to CPN – no other information offered
R5Male: Setting 2	Answer-phone message to say he didn't know who I was or how I had got his address and that he did not wish me to contact him
R6Male: Setting 1	Said no to CPN– no other information offered
R7Male:Setting 1	Message from CPN that he had said "Absolutely no-way"
R8Male:Setting 1	First response via CPN "recent death in family, try again in future" Second response via CPN "I saw [service-user] this morning and he feels he is not able to partake in your study. He still has a lot of his own issue's going on at the moment"
R9Female:Setting 2	By phone "I'm awfully sorry but I have decided not to take part in your study, going through my past would be a bit traumatic for me"