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Title: Resistance and challenge: Competing accounts in aftercare monitoring in forensic psychiatry:

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The definitive and final version of the paper can be accessed via the link below http://onlinelibrary.wiley.com/doi/10.1111/j.1467-9566.2010.01321.x/abstract

ABSTRACT
This paper explores a candidate example of competing accounts of aftercare under supervision of a discharged forensic patient and worker in one part of the UK. It is taken from a study involving 59 in-depth interviews with patients and their workers to investigate community return after detention in forensic psychiatric facilities. Fear of mental illness and associated dangerousness are embodied in discourses surrounding the forensic patient. In living with deviant labels and seeking to establish independence from the psychiatric system patients’ talk demonstrates nascent identity work in an attempt to resist alternative dominant discourses. Workers however deploy occupational knowledge of risk and associated monitoring as the basis for claims of safe aftercare. Both patient and worker accounts are reflexively aware of competing versions and seek to portray the provision of aftercare monitoring in self-interested ways. Aftercare monitoring and supervision may ostensibly be about integration and rehabilitation but as this study shows risk is an ever-present concern forming an important backdrop to the attempts of patients to forge new identities and the normalising ideologies of those working with them.

INTRODUCTION
This paper presents a case study based on interviews carried out with a service user and a professional care worker involved in the processes of leaving hospital and continuing aftercare from forensic mental health teams. The analysis that follows
examines competing accounts produced in interview talk that show divergence in treatment goals and claims to nascent identities. Forensic mental health is a term applied to mental health care provided by specialist health and social care teams to people who have usually been convicted of a criminal offence and for which the mental illness label is deemed applicable. Being in receipt of these services thus makes available two overlapping sets of deviant labels: implicating criminality and illness (Aubert and Messinger, 1958). Leaving hospital and attempting successful community integration consequently raises issues of identity and adjustment, posing a significant challenge for those involved.

Discharge from forensic mental health settings is often conditional upon a range of social control measures including aftercare monitoring and supervision. The principal legislation governing detention and treatment of people with mental illness in England and Wales at the time of this study was the Mental Health Act 1983. Section 37 of the Mental Health Act allows a Crown Court to detain a person, on conviction of a serious offence, in hospital for treatment. This is often used in conjunction with Section 41 which prevents and restricts discharge unless granted by the Ministry of Justice or a Mental Health Review Tribunal. Discharge is usually approved on a conditional basis subject to aftercare monitoring arrangements that can include attendance for treatment, permitting the care team access to living arrangements, attendance at organised activities and restrictions specific to the individual, including limits on travel or contact with specified persons. In all cases the Ministry of Justice retains the right to recall individuals to hospital.

Conditional discharge takes place within a context of heightened public fear of the mentally ill (Hannigan 1999) and political moves towards using mental health legislation to control dangerousness (Manning, 2000). Risk thinking is pervasive to the extent that decisions on care and treatment are influenced by considerations of risk (Godin, 2006), leading to self-protective or even defensive strategies that are neither in the interests of patients nor workers (Annandale, 1996). Services may seek to provide progression towards eventual discharge and greater liberty but movement may occur in the opposite direction too (Heyman et al, 2004).

The concern to predict and manage future behaviours has become a central and core task of mental health work (Godin, 2004). This reflects a wider societal risk-aversive culture in which perceptions of high-profile but low-probability risks are associated with public anxiety for state intervention, while low-profile high-
 probability risks are accepted without concern (Lupton, 1999). Since most standardised measures of risk are based on historical and therefore static factors, it remains unclear how patients can escape the judgements of risk assessment procedures and achieve downwards movement on the risk escalator (Heyman, 2005).

Moon (2000) has suggested that failures in supervision of mentally ill people have resulted in a new discourse of confinement. The move from hospital to the community is not a one-step process towards independent living, but is broken-up into ever smaller steps, each subject to rigorous management. This in effect elongates the risk escalator towards eventual absolute discharge (Heyman et al, 2004). Utopian and libertarian ideals of independent living supported by community mental health teams are jettisoned so that mentally ill people have swapped one type of institution, the mental hospital, for new institutional arrangements involving more subtle forms of supervision within the community (Cohen, 1985; Steadman and Morrissey, 1987; Armstrong, 1995). Legislative amendments in the Mental Health Act 2007 have further conflated notions of mental illness and dangerousness and thereby reinforcing Dallaire et al’s (2000) contention that if these criteria are interchangeable then so are the finalities of treatment and control.

A serious criminal conviction leads to a view of the person as a “true outsider” (Becker, 1963:3) and coupled with mental illness suggests significant implications for individual identity. Deviant labels create a range of social hurdles for persons who attempt to re-establish themselves within the wider social group (Link et al, 1987). The support of workers is required to achieve discharge and this necessarily involves agreement about what is relevant in the processes of aftercare. However the extent to which patient and worker accounts of aftercare agree or disagree remains unclear.

Rose et al, (2006) have noted that most research in mental health care is written from the perspective of professional workers who determine what counts as evidence and how it should be interpreted. Studies of service user views have largely failed to provide equivalent accounts in which individual voices are heard, so that versions offered have a homogenous quality that in-effect downplay difference and resistance. As Briggs (1996) intimates, maintaining and preserving these parallel narratives through first-hand accounts allows conflicts to be examined 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 provides the opportunity to lay clear the separate stances regarding identity
claims that must be negotiated and ultimately accommodated in patient-worker interactions.

Mishler (2005) argued that patient stories have a declining role in medical decision-making leading to more technocratic approaches to health care. Highlighting resistance in accounts of health care can allow a balance to be struck between understanding what it is that makes people ill and understanding the consequences of illness as experienced by the person (Sullivan, 2003). It is my contention that examination of the accounts of socially positioned people subject to aftercare monitoring will demonstrate new understandings about the work they do in managing their community return. This work may include the construction of new identities. The extent to which new identities are viable and are supported or challenged by workers may influence outcomes of re-integration attempts.

THE STUDY
The larger study on which this paper is based set out to analyse everyday understandings in accounts put forward by discharged patients and workers involved in aftercare monitoring from two forensic mental health settings in the UK (Coffey, 2008). Telling a story of an experience is an accessible way to talk about past events and to address a range of experiences. It is also one way in which social actors construct identity performances. Face-to-face encounters allow actors to account for both their view of themselves, and the social world around them (Scott and Lyman, 1968). The focus of analysis in this study has been to examine narratives paying special attention to what was being said, what this worked to accomplish and how this was achieved (Edwards, 2006).

Scheid-Cook (1993) has suggested that those subject to formal social controls are unlikely to challenge dominant ideologies with workers for fear that it could lead to further loss of liberty. In-depth interviews, rather than studies of interaction, may provide opportunities for a relatively oppressed group to voice resistance.

Approval for this study was gained from two Local Research Ethics Committees in the relevant geographical areas. The sample consisted of 18 men and 2 women subject to aftercare monitoring (Section 37/41 of the Mental Health Act 1983), ten social workers providing social supervision under the Act and ten community psychiatric nurses (CPNs). The full data-set included a total of fifty-nine audio-recorded and transcribed interviews. The approach in research interviews was to prompt respondents to tell their stories of discharge and follow-up aftercare.
One aspect of the analysis of these data, namely competing accounts in aftercare monitoring, is discussed here using a case study from the larger data set. While examining the accounts of workers and patients it became apparent that the versions offered often included non-compatible claims. Discrepancies between worker and patient accounts may signal problems in agreements about treatment goals (Anderson et al, 1989). To this end I present analysis of extracts of talk of two participants as candidate examples of resistance and challenge in patient/worker accounts. I do not claim that these differences in accounts occurred in all circumstances however they were numerous enough to suggest that they were far from unusual. Participant names used in the following analysis are pseudonyms created to maintain anonymity.

LIVING WITH AFTERCARE MONITORING
Aftercare monitoring under Section 41 of the Mental Health Act 1983 in practice is usually taken to warrant a high level of supervision, scrutiny and control over the lives of discharged patients. 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 patients and workers that continued and ongoing aftercare monitoring is necessary for the protection of both the individual and the wider community. Participants subject to aftercare monitoring had a sense then that they were someone who had “got to be kept an eye on” (participant Martin: line 299). 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 leaving hospital and the terms of their discharge. For instance, those living in independent accommodation were seen by workers at most once or twice a week, and two participants in this study were required to be in the company of a housing support worker at all times. The perception of control implied in such close supervision was convincingly summed up by one participant who alluded to being like a puppet, “they’ll be getting some strings next and dangling me on strings” (participant Dave: line 438).

The background for these accounts is then one of significant levels of monitoring and supervision within which patients’ efforts to assert new social identities are kept in check or actively challenged by workers. One way of reading this is as an attempt by workers to establish the dominance of a professional version of a normalising ideology (Anderson et al, 1989; Gray 2001). The strong structural imperative of conditional discharge and aftercare monitoring forms an important backdrop to how
identity is worked-up and rehearsed in turn-by-turn interaction by patients with workers and others.

The extract presented below is taken from the second interview with Iestyn, a man in his mid-thirties who had been discharged two years previously. During the interview Iestyn described a post-discharge identity of a young man involved in a counter-culture of music collecting, late-night parties and Goth-type paraphernalia. Iestyn’s account comes in the form of a complaint about the threat of being recalled to hospital if he should be found to be smoking cannabis.

I: one of the things you were just saying as you were making your drink was about the stress of being on a section 41
R: yeah it is stressful you know. A lot of people on it um in mental hospitals have (3) some link with drugs you know cannabis or whatever (2) and it causes stress not only in hospital but when you leave too I think. [takes a sip of his coffee] (7) Because you’re on that section (2) you know um when you get released you sometimes get conditionally released. And those conditions can be to stay off drugs and stuff like that you know and I knew one or two people who’ve been readmitted for smoking cannabis and having urine tests and coming back positive and they recall you then because this guy I’m thinking about he wasn’t meant to be smoking it either and he got readmitted that was at [hospital] when I was there.
I: so that’s a current concern for you?
R: a little yeah. You see the thing is if, they don’t cast as much shadow or you know they don’t frown upon people, they don’t say like don’t touch heroin, don’t touch cocaine, its only cannabis you know. It’s actually a very soft drug cannabis is, it’s exactly the same as um alcohol and cigarettes. The number of people you know in the pub, let’s go and have a spliff now go home and have a spliff like, you know and then again people smoking bongs, that’s a slightly different, they’re like groups, you get groups of people you know. You get these people who’ll go home and have a bong next or something. You get these groups, you know in Amsterdam they even dropped it a class. They could drop it another class or they could just make it legal like in Amsterdam I think.
I: It seems people might be more worried about cannabis or about drugs more generally, are you having urine tests?
R: I do yeah.
I: How often does that happen then?
R: It’s whenever they want to. They can give you a urine test here I’m talking about now anytime they want to.
I: And that has happened before?
R: I’ve had urine tests yeah.
I: And how has that been?
R: Umm, (2) they found out that I was smoking cannabis. I had to stop smoking it because if I hadn’t, I went into hospital voluntary just before Christmas for two weeks, (2) they called it a respite but supposedly something about if I hadn’t gone in voluntary there was a possibility that I might’ve got recalled. If you’re recalled that means you are readmitted into hospital, they don’t have to put a section on you, all they got to do is put a 37 in front of my 41, cause the 37 is the hospital part and I would have to stay there and have a tribunal to get out. I’d be in there minimum a year, could be anything more than a year, could be a year and a half because they’re going to say he’s going to go back out and smoke it again or something. It’s like catch-22 and as I was saying it’s not a hard drug, there’s a lot of people who, some
people who smoke a lot of it they smoke it all the time you know and they become addicted to it in a way because it’s like (3) you get used to it, it becomes part of life smoking that.

[Iestyn second interview: setting 2: lines 8-47]

Iestyn’s account provided the perspective of someone who was subject to multiple levels of overt social control, backed by the authority of medical knowledge. This knowledge is based in part 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 violent 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 (Doyle and Dolan, 2007). It is likely that this knowledge would have been communicated to Iestyn by workers in an attempt to educate (socialise) and provide a rationale for establishing compliance with aftercare arrangements. Iestyn indicated that he was effectively helpless in the face of the likely sanction should he resist or fail to comply with requests to stop using cannabis. His attempts to assert that cannabis use is normal behaviour can be read as an appeal to more liberal understandings of recreational drug use (lines 21-24 and 46-47). This worked to make his claims appear sensible or even mundane (‘it’s actually a very soft drug’ line 21) which might solicit support for his position. The sequential organisation of his account functioned to establish cannabis use as normative and allows the reconstruction of the clinical team’s responses as unreasonable.

Gray (2001) had suggested that narrative reconstruction is a form of resistance to normalising ideologies. Iestyn’s account worked to create an alternative to the normalising ideology of abstinence from illegal substances in aftercare arrangements. He employed as a resource the legal classification changes and highlighted his own categories to indicate that there were ‘groups’ for whom such use was normal (lines 22-26 and 45-47). Claims about the ambiguity of public policies, and the construction of groups of people whose behaviour differs from the mainstream (‘it’s a very common thing now’ line 25), help to build Iestyn’s case. These claims worked to set-up a contrast with how workers impose what might now be seen as overly strict conditions.

Iestyn’s story also had the qualities of what me might term an oppressed discourse. The attempt to solicit support may be one feature of this. He achieves this in part by providing a story of someone who was recalled to hospital following a positive urine
test (lines 14-17). His talk also 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. His account can be heard as expressing concern about this omnipresent omniscient total state. Iestyn 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. His 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. Iestyn employs a rhetoric of polarity: “they” could drop cannabis another class or even legalise it and yet he is threatened with being locked-up for using a common, “soft” drug. This contrast worked to present the situation the speaker found himself in as having no satisfactory exit route.

The reference to “catch-22” can 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 onerous conditions of discharge. Constructing the liberal cannabis smoker as being part of who he was is a somewhat delicate identity to achieve. It may be difficult to secure support for this version when associated with commonly held notions of chaotic or disruptive mental illness (Hannigan, 1999). The allusion to “catch-22” appeared in other accounts provided by patients in this study and in each case it worked to secure support for complaints about the nature and intensity of aftercare monitoring. Aftercare monitoring as a form of total social control is perhaps a facile allusion (Lowman et al., 1987). However Iestyn was providing the account from the inside. The account worked to construct the constant threat that his risk behaviours were being monitored and that negative assessment of these would result in a loss of liberty.

Iestyn’s story was designed to display its orientation towards other available accounts. His talk functioned to resist the discourse presented by health and social care workers. That is, despite the counter versions available, smoking cannabis was presented as normative for some people who smoke it all the time. Iestyn does not refer to risks associated with cannabis use and mental illness designations in this extract nor anywhere else in his account. Indeed the only risk which his account acknowledges is the risk of recall and further detention in hospital. This orientation clearly signals that competing accounts are available but, rather than address these
directly he presents an alternative version that advances his claim as an oppressed cannabis smoker.

Identity-rich labels which are accorded valued status feature as important orientations in talk (Antaki and Widdecombe, 1998). In using these (“people you know in the pub” Line 22) Iestyn was denoting membership of socially-valued categories and as such they are important resources for the work of establishing consensus for new and emergent identities. Consensus however is not so easily secured and worker accounts often demonstrated different sets of concerns with post-discharge identities.

PROFESSIONAL VERSIONS OF AFTERCARE
Workers constructed alternative versions of aftercare monitoring in relation to continued 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 presented as 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 the exception of the prescription of medication, workers have limited options in managing the uncertainties of another’s behaviour once discharged from hospital.

Iestyn’s concern with recall was evident in the talk of his community psychiatric nurse (CPN) who appeared ready to exercise the authority that aftercare monitoring allowed. The following extract is taken from a research interview conducted in the clinical team offices approximately three weeks after my second meeting with Iestyn. The CPN had known Iestyn for ten years.

231 I: Has the restriction order been helpful or unhelpful in helping him to resettle in the community?
232 R: I think you know somebody like [Iestyn] it is helpful with his history like you know I mean umm (4) personally I think you know if he wasn’t on an order or conditional discharge he would not come for clozaril bloods to be honest with you, he would come off the drugs and go on the drugs he prefers to be on, (1) you know.
237 I: 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 having to recall him it was one of the things that helps us and the 117 meetings have been helpful as well. (2) The 117 meeting you know that we hold for him as well I mean obviously if he wasn’t under a section you know he wouldn’t have been subject to that anyway.
242 I: So that gives him [another sort of

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The CPN implicates Iestyn as a particular category of person. The presence of a category was established with the phrase “somebody like [Iestyn]” (line 233). The cue that a categorisation was being used was then supported in the following lines with an explanation that Iestyn was to be seen as unreliable. Without the restriction order Iestyn “would not come for clozaril bloods” (line 235). This was to be understood as a particularly risky type of unreliability and had already been mentioned, “he started missing out the outpatients for clozaril bloods” (line 100). One effect of clozaril is that it can cause sudden decreases in white blood cell counts, leaving the recipient vulnerable to severe and potentially fatal infection (Krupp and Barnes, 1992). The requirement to attend for monitoring blood tests is a condition of taking the medication. Failure to attend for these blood tests was then to be seen as being tantamount to a type of recklessness of “somebody like [Iestyn]”.

The use of categories is significant in talk because they open the way for inferences about the likelihood that members will engage in known category-bound activities (Sacks 1992). Categories do not simply appear in talk, they are used to act (Antaki et al, 1996). Griffiths (2001) for example, has shown how community mental health workers engage in categorisation in referral meetings as a way of steering cases towards certain dispositions and thus managing workload pressures. The use of a category by the CPN indicated that a problem existed for which a response was required (Emerson, 1983). It worked to signal that Iestyn’s lack of rationality warranted the use of statutory controls. The CPN follows the identification of the category by populating it with further information about the ‘drugs’ (line 236) that Iestyn prefers to use. This functioned as a means to build consensus that Iestyn’s choices were to be seen as illustrative of the category of unreliable and chaotic people. He was someone who needed to be kept ‘an eye on’ (lines 243-244) and whose welfare had thus become the responsibility of workers.

The CPN directly alludes to existing alternative accounts when he indicates that the restriction order is “helpful with his history” (line 233). This history was incrementally constructed throughout the interview as including behaviour which was “very
demanding” (line 26) and “very insulting” (line 29) and directly opposing the conditions of discharge by smoking cannabis (lines 93-94). This can be understood as being part of the risky category of “somebody like Iestyn”. Iestyn’s attempt at working-up drug use as normative practice is directly challenged by the CPN who indicates that this history of coming “off the (prescribed) drugs and go on the drugs he prefers to be on” (lines 235-236) does not fit with the orthodox consensus within medicine about the risky effects of cannabis use (Steadman et al, 1998). Indeed the CPN indicated “every time you tell him about cannabis he says well it’s legalised so umm, you know” (lines 194-195). Cannabis smoking was therefore a site of contention between Iestyn and his workers where different versions of what counts as normative practice vie for dominance.

The categorisation “somebody like [Iestyn]”(line 233) worked to downplay anything that Iestyn might have said that challenged or resisted the social control measures employed by workers. The CPN’s account can be read as rhetorically organised to address competing accounts such as those already provided by the service-user. These references to Iestyn’s drug use (line 236), his lack of compliance (line 245) and his ‘difficult’ behaviour (line 113) are evident throughout the CPN account and work to construct Iestyn as unreliable and therefore untrustworthy.

The account illustrates the reflexive awareness of the CPN in portraying a version of aftercare monitoring that functions to counter any critical accounts from service users. The use of the categorisation in the opening lines provided space for filling in the details of the version offered. The story line in essence is that unreliable or risky people need to be helped, and that aftercare monitoring helps the helpers to ensure that people get this assistance. This version however was open to a challenge either directly in the interview interaction or from a secondary source such as Iestyn himself. For instance it has been argued that the level of intrusiveness and lack of reciprocity of newer forms of post-discharge control outweigh any benefits (Eastman, 1994). In the early part of this interview the CPN constructed his case for the claim of an unreliable, demanding, difficult and risky individual. Close examination of this extract shows that the respondent 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, “keeping an eye on him and his welfare” (lines 243-244). Section 117 meetings are statutory discharge planning and review meetings required under the Mental Health Act 1983 and oblige the clinical team to meet with the person and their carers to review progress and make alterations to
treatment plans. Iestyn’s resistance was thus further cast as irrational in contrast to the well-meaning and valuable work of the team. The speaker explained that, apart from facilitating judgements about whether recall to hospital might be justified, these meetings “are helpful as well” (lines 239-240). 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” (line 240) 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 switch in the way the account was presented was perhaps an attempt at reaching a moral resolution in an area of practice where workers are not wholly indifferent to the claims of patients (Scheid-Cook 1993). As if to highlight and conclude this shift of emphasis the speaker indicated that “it works both ways really” (line 244). This reads as a considered balancing of dominant professional ideologies of control and the more altruistic intention to offer care (Mason and Mercer, 1996). It is the production of an acceptable account for the purposes at hand. This was ultimately unconvincing, however, as after a long pause (line 244) the speaker indicated that he was oriented to using the statutory order to insist on compliance with treatment conditions. The implication in this account is that the level of presumed risk constitutes a sufficient warrant for more coercive interventions by workers. This analysis suggests that Iestyn’s concerns about likely negative effects of aftercare were realised in the CPN account in which a readiness to use the implicit threat of recall was evident. It gives a distinct flavour of the normalising ideology that Iestyn may have experienced in his interactions with workers and perhaps more importantly the potency of the underlying power of professionals. Iestyn’s attempts to assert agency in the face of professional dominance may have been unsuccessful but despite this his resistance persisted.

Normative practice in forensic aftercare involves workers orienting towards medical explanations for risky behaviours. This context forms the background for discussions, negotiations and interactions between patients and workers. Accounts from patients often constructed length of detention and continuing aftercare as disproportionate. This is a recurring feature in accounts of conditional discharge both in this study and elsewhere (Dell and Grounds, 1995). However dangerousness itself is perhaps a more hidden and frequently difficult to dispute counter-claim for people who have been arrested and convicted for violent behaviours. The headline issue presented by workers and in the professional risk literature is how to enable the
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least restrictive option of community care while maintaining responsibility for, and monitoring of, risk behaviours. The extent to which concerns about dangerous behaviours are openly discussed between workers and patients is uncertain (Langan and Lindow, 2004). Notions of risk embodied within the dangerous patient have significant weight for, as Annadale (1996) has noted, there is always the possibility of future risks arising as a result of current practices. In forensic settings this concern about future risk is reinforced by any previous history of violent behaviours. The opportunity for patients to shake-off dual labels of madness and badness is therefore limited. It appears, however, that if risk is discussed at all it may be by means of consultations in which normative expectations are communicated to patients by workers. Open resistance is interpreted as indicative of noncompliant, and therefore risky, behaviour and as such may be driven underground. However the competing priorities of both patients and workers do not appear to be easily reconciled, in large part because of the mobilisation of the over-riding imperative of public protection.

People who are considered risky cannot simply be discharged from hospital but must somehow be ‘managed’. Leaving forensic mental hospitals is a highly scrutinised and supervised process in which the person remains available for monitoring within the wider medico-judicial system. Workers effectively operate as moral enforcers (Becker, 1963) maintaining expectations of what is to be seen as normative in post-discharge identities (Erikson 1962). In their accounts they establish and sustain their primary claim to be protecting the public. Patients for their part are engaged in repeated identity rehearsal, trying out new versions to establish what is viable. Their accounts can be seen as attempts to work-up and deploy these identities for the purposes of determining their longer term suitability to live in social settings. Identity claims surface often in interactions between patients and workers but are frequently challenged. The CPN in this account makes clear that the liberal cannabis smoker is not an identity supported by normative ideas of forensic mental health. These attempts at identity-work by patients are not readily surrendered however and their presence signals resistance to the normative discourse of workers.

The deployment of risk discourses in post-discharge work means that many patients will remain in heavily institutionalised regimes, albeit outside hospital (Lowman, et al, 1987). Here the notion of discharge from hospital is effectively turned on its head. Patients who were once locked inside secure institutions are now locked into risk management regimes which are every bit as difficult to negotiate. Constructions of
risk and dangerous patients are deployed by workers to justify continued monitoring but in doing so they also constitute what aftercare monitoring is understood to be.

One outcome of subjugating treatment goals to concerns about risk in clinical interactions is that this has the potential of unmasking shortcomings in post-discharge work. It may then be seen to be a poorly veiled attempt to apply social control measures for the longest time possible in the absence of alternative viable treatments. The rhetoric of partnership and collaboration deemed necessary for successful intervention (Beresford, 2000) is unlikely to be realised as the goals of treatment give ground to the imperative of risk. Patient accounts suggest that they are alive to this prospect and worker accounts, perhaps in recognition of the limited evidence base for their interventions, focus almost entirely on the public protection benefits of their involvement.

CONCLUSION
From the research interviews it was clear that many patients were locked into deviant identities by the weight of events surrounding their cases, and yet it was striking that persons convicted of very serious offenses, including murder and arson, nevertheless struggled to construct many features of their lives as ordinary and unexceptional. Interestingly while patients constructed deviant labels as historical, workers oriented towards these as current, thereby challenging emergent identity work. This may have been a way of displaying an awareness of contemporary concerns with risk status and thus may reflect a form of occupational identity work. Certainly 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 results in mental health workers being so constrained by bureaucratic structures that they become mere functionaries whose practice is governed by concerns of risk. I am suggesting however, that in interaction workers utilise risk discourse as a resource to promote normative occupational ideologies. These function as claims to jurisdiction over which post-discharge identities are to be seen as most salient and legitimise social control measures.
For their part patient accounts function to claim alternative, and sometimes clandestine versions of resistance to the dominant discourse. Attempts to resist or attenuate the force of deviant labels may as Reissman (1990) suggests, help to heal discontinuities in the nature of the self. Both sets of accounts show awareness that discrepancies between and within versions exist. Patients attempting to integrate discrepant aspects of personal biographies nevertheless struggle on tenaciously with attempts to establish viable new identities, even when these appear untenable and doomed to failure.

The processes of receiving and responding to discharged patients’ identity claims may be subtle and it is not clear if overt moves to challenge or deny such claims are common in day-to-day interactions with workers. Probably these issues are not specific to aftercare monitoring. Normalising ideologies are a feature of the talk of health workers more generally (Waitzin, 1991) and operate as one of the newer forms of social control coincident with the decline of total institutions (Anderson et al, 1989). Some patient participants were happy with the level of care and easy access to workers that aftercare monitoring offered. There was however a tendency towards greater expressed dissatisfaction among those with established community tenure. My analysis shows that patient’s accounts express the difficulties of trying out newer identities that are discordant with the dominant ideologies of workers.

TRANSCRIPTION CONVENTIONS

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

ACKNOWLEDGEMENT

I am grateful to David Hughes and Aled Jones at Swansea University and Ben Hannigan at Cardiff University for comments on earlier drafts of this paper.
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