Time and its uses in accounts of conditional discharge in forensic psychiatry

Michael Coffey
Associate Professor
Dept. of Public Health, Policy and Social Sciences
College of Human and Health Sciences
Swansea University
m.j.coffey@swansea.ac.uk

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**ABSTRACT**

Time is a recurring feature of storied accounts of health and social care. This paper addresses the use of time in accounts of conditionally discharged patients and workers in forensic psychiatry. This study contributes new knowledge about time and its uses by a seldom heard group. An analysis of time-relevant discourse taken from 59 in-depth interviews with patients and their workers is provided to show regularities and discontinuities in schedules of post-discharge supervision in community living. Regularities included timed phases for achieving discretionary permissions for greater liberty from services. Discontinuities indicate mismatches between hospital and community time and patient and professional time. Benchmarking by patients is an important resource and allows comparisons and measurements of stages in the discharge process. Discharged patients showed awareness of deviance and implicated time as an important resource in claiming ordinary identities. Participants demonstrated progressive stories to show incremental movement towards recovery and, ultimately, non-deviant identities. Workers use time as just one part of a complex display of professional judgement of continued risk status. Fixed periods of elapsed time are necessary but not sufficient criteria for workers to reduce surveillance. Time remains a useful resource for patients to chart their way towards more routine identities.

## INTRODUCTION

This paper presents an analysis of the use of time in accounts by conditionally discharged patients and those working with them to provide follow-up care, support and monitoring. Conditional discharge refers to a process of graded discharge from forensic psychiatric settings in which the person remains subject to decisions of workers including enforced return to hospital. The *Mental Health Act 1983* (as amended 2007) provides the legal means for detention for treatment in lieu of a prison sentence through Section 37 in England and Wales for those convicted of criminal offences occurring in the context of diagnosed mental ill health. Forensic psychiatric settings range from national high security prison-like hospitals through regional medium security units and low security and community-based services. Additionally Section 41 allows for hospital discharge to be restricted subject to Home Office approval and once granted this is accompanied by a series of conditions related to aftercare monitoring and continued treatment, attendance for treatment or day time activity, access to living arrangements and possible curfews or limitations on movement. Continued aftercare is effectively mandated by Section 41 and is indeterminate with some individuals remaining subject to these conditions for the remainder of their lives. Establishing timetables and benchmarks for complete discharge from these requirements is something that patients continually address in their accounts. One reason for this is that individual identity is closely bound-up with aftercare because while this continues the person remains linked with previous events that led to their designation as a forensic patient (Coffey 2012).

In many settings leaving hospital can be a relatively straightforward process. An everyday understanding of hospital discharge is that once a person has received treatment for their condition they can then return to home and work life with little or no further planning. Nolan et al (2011) however noted that for many people receiving inpatient psychiatric care there is a need for better preparation for discharge from hospital where follow-up aftercare is seldom mandated. In non-healthcare settings too such as prisons there is recognition of the need for better preparation and follow-up of released prisoners especially among those with mental health problems (Lurigo et al, 2000). Many of those detained under Section 37 and subject to Section 41 restriction of the *Mental Health Act 1983* (as amended 2007) have been detained for lengthy periods; many will have lost their homes and their jobs in the process becoming disconnected from social networks. There is no set tariff for length of detention of forensic patients unlike prisoners so agreement from workers is required for discharge. Discharge for forensic patients is also dependent upon a number of contingencies such as the availability of suitable accommodation and willingness to comply with aftercare supervision.

Legal and policy constraints provide an important backcloth in which patients engage with workers and negotiate the variable conditions under which discharge may be granted. The wider moral context of policy provision is exemplified in the contested nature of mental health legislation and policy in England and Wales (Cairney 2009; Hannigan and Coffey 2011). Patients and workers therefore find themselves locked into a system, sometimes transcarcerative in nature (Lowman et al, 1987), which although mutable remains politically contingent in the historic moment (Manning 2000; Pilgrim and Ramon 2009). Efforts by individuals to accomplish the moral patient are therefore frequently challenged by the structural and professional contexts of aftercare supervision (Coffey 2011).

In total institutions such as maximum security prisons social order is negotiated and control is far from complete (Thomas 1984). In healthcare settings Strauss et al (1963) suggested that "different echelons" within professional staff groups see getting better differently so that while there may be agreement on basic goals there may be little consensus about the means to achieve these. Disagreements that necessitate negotiation are patterned. This patterning indicates variation among and within professional groups with regard to the work of providing mental health care. Clarke (1996) has previously shown patterning among nursing staff in one forensic setting such that two distinct groups, which he called carers and controllers, indicated different approaches to care provision. Public protection may be an agreed basic goal or compact among workers in forensic settings but the means to achieve this and decisions on how, or if, it has been achieved may differ. Thus patients and workers are engaged in bargaining, give and take and negotiation to establish what constitutes sufficient improvement to accomplish the precise timetable that applies in individual circumstances.

Time is an important and taken-for-granted feature of social life, helping to conceptualise the past and imagine the future. Adam (1990) noted that conceptions of time matter in everyday life, identity, social participation and our relationship with death. Indeed industrialised societies use time as "a standardised principle for measurement, co-ordination, regulation and control" (Adam 1990:9). However understandings of time go beyond clock or calendar time to include time as a commodity and a resource that can be spent wisely, saved or wasted. The use of time by social actors may then be seen to hold moral value and is evident in the stories that people tell about themselves and others.

A common and perhaps unique feature of stories is their ability to address the passing of time and the sequencing of events. Stories provide the means of placing the individual within a wider social system (Bergmann, 1992). For instance, Torre (2007) has noted there

are commonalities in the talk of social agents in relation to temporal elements of their narratives. These commonalities include widespread time metaphors that function to shape the world around us and deploy temporal resources for action. One such metaphor suggests Torre (2007), is time as a horizon of intention. 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. Horizons are always moving and not reachable from the present but they do indicate possibilities or previously visited territory. Torre (2007) sees the use of time metaphors in talk as one way of constructing meaning and identity through narrative. 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). Social actors not only derive understanding and meaning from their lives through temporal narratives, these understandings make social action possible. Identity can be constructed in part based upon previous horizons but also with reference to future directions.

Zerubavel (1976:89) had 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"

Zerubavel (1976) indicates that regularities, sequencing, tempo and routine are all areas in which a sociological investigation of everyday life can help to reveal the standard conventions which social actors orient towards in their daily business. This can include how the social organisation of time contributes to and sustains elements of social control in cases where particular institutional patterns or schedules are seen to over-ride those of the individual.

Stories provide the means to relate fragmented occurrences across time and contribute to the formation of identities. The experience of mental ill health itself is known to signal particular social identities (Goffman 1963). Hyden (1997) has suggested that illness experience ruptures temporal continuity creating problems in personal identity that need to be resolved. Bury (1982) had previously argued that this 'biographical disruption' was at the heart of attempts to knit together compelling narratives of illness for the purposes of making sense of worrying and chaotic experiences. In forensic psychiatry time may have a number of additional functions for patients. For example, people detained in forensic psychiatric facilities will often spend many years separated from their support networks. Additionally the weight of previous events in the form of dangerous or risk behaviours is brought to bear in the present and continues to carry ramifications into the future for the individual. It has been

shown that stories of illness provided by discharged forensic psychiatry patients are deployed as mitigation for the purposes of accounting for past dangerous behaviours and reconciling attempts at new identity work (Coffey 2012b). Narratives may therefore be seen as achieving coherence and direction across time and contribute to the historical emerging self. This paper identifies schedules and discontinuities as recurring features of the talk of people discharged from forensic psychiatric settings that work to establish credibility and distance from previous events as an additional strand in accomplishing new identity work.

**THE STUDY**

The approach in this study has been to examine everyday displays of understandings (Garfinkel, 1967) in accounts told by discharged patients and workers involved in aftercare monitoring from two publically funded medium security forensic mental health settings in the UK. These settings provided inpatient and aftercare services to a large geographical region consisting of both densely inhabited urban areas and sparsely populated rural areas. The settings provided for the preparatory stages of discharge as well as aftercare monitoring and supervision.

Telling a story of an experience is 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 with a specific interest on what was being said, what this worked to accomplish and how this was achieved (Edwards and Potter 1992). This approach is concerned with examining people's practices such as communication, interaction and argument. It recognises that accounts function to achieve particular ends in that they persuade, argue, convince and show awareness of competing versions. Edwards and Potter (1992) argue that this approach positions language as representation subordinate to language as action. The focus of analysis was on what purposes talk was put to by speakers themselves. This approach was used to examine accounts told by actors and in doing so it was possible to see the self-interested ways in which these operated.

Approval for this study was gained from two Local Research Ethics Committees in the relevant geographical areas. The purposive 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). A further nine patients declined to participate. The full data-set consisted of fifty-nine audio-recorded and transcribed in-depth research interviews. Two patient participants

chose to be interviewed twice and some workers were interviewed more than once as they worked with multiple patients. The approach in research interviews was to prompt respondents to tell their stories of discharge and follow-up aftercare. Participant names used in the following analysis are pseudonyms created to maintain anonymity.

The transcribed research interviews amounted to over 350,000 words in 59 separate documents. Transcripts were coded following the process identified by Braun and Clarke (2006) to produce a detailed and exhaustive category system of issues raised in each interview, and to link interviews and categories together. The focus of analysis then moved to considering the sequential organisation of talk and the discursive actions which accounts worked to achieve (Edwards and Potter 1992). For the purposes of this paper analysis has been extended to consider explicit use of time references in accounts including regularities, discontinuities, benchmarking and use of temporality to achieve transition to new routine or ordinary identities. These schedules included process events such as formal and informal stages in return to community living which 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.

**REGULARITIES AND DISCONTINUITIES**

It is perhaps not unexpected that people detained in forensic settings and denied liberty to engage in their usual social networks should focus their accounts upon the timetables and schedules of these settings (Roth 1963). The duration of detention while not a specific focus of this study, was nevertheless often referred to by patients and workers alike. References to time served or time passed function to establish authenticity and credibility in accounts about the systems of care. This is achieved with references to hard won knowledge over many years that furnish accounts with a difficult-to-dispute quality. Participants in this study were asked to tell their stories about preparing and returning to community living. Almost without exception their accounts referenced the staged nature of the process of gaining discharge with reference to very specific time phases. These schedules were not formalised into a set of written rules. Nevertheless both patients and workers consistently oriented to particular timeframes for detention and aftercare implying that regularities existed despite the indeterminate nature of the order for detention and treatment.

All service-user participants described a staged process of gradually increasing levels of parole from the forensic mental health facility, leading up to their conditional discharge. ‘Parole’ was a term commonly used by both patients and workers to describe the phased periods of leave spent outside hospital. The term itself is reminiscent of that used in the

prison system. These periods of leave were usually granted by the clinical team and sanctioned by the Home Office. Skelly (1994) has noted that service-users construct these paroles as 'stepping stones' toward eventual discharge and this notion of pacing of care provision was a feature of stories told in the current study. Scrutiny by professionals of progress 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' (Keith: Setting 2, line 197).

Another participant, Lloyd, who had been detained for more than 4 years in medium secure settings, noted the staged process expressed in specific timed event periods continued up until discharge had been formally agreed.

> P:…well just to come here that's all, a few weeks of sort of starting here and a room here and (2) I came here a few days a week just sort of coming and going back to [forensic psychiatric facility], started doing that for a few days (1) a week and then after the tribunal, moved in straight away. Easy then but once the, you know (2) it's been a long time but I've gone with it.
>
> (Lloyd: Setting 1)

Regularities were also evident in accounts of post-discharge monitoring and aftercare. Tony who had spent two and half years detained in a forensic psychiatric facility provided a typical account focusing on the regularity of his contact with workers post-discharge.

> I: you have being seeing [CPN] most of that [time…
> P: yeah], every other week yeah, I see [social worker] one Monday, her [CPN] Friday, [psychotherapist] on a Wednesday, but they chopped it back now about a month or so back, I see [social worker] every other week and [CPN] the second week and I see [psychotherapist] then in between
>
> (Tony: Setting 1)

Post-hospital temporal regularities are an important feature of conditional discharge and aftercare because they signal expectations about sequencing and duration for both patients and workers. Workers construct these regularities as an extension of the stages experienced in hospital. In both cases the promise is a lessening of supervision and monitoring at some distant but rarely defined future date. Patients use these regularities not only to show adherence to schedules but also as a means of comparison with others. In the context of conditional discharge adherence to schedules is an important moral signifier demonstrating time served and perhaps more significantly obedience to both social and official rules.

Participants were concerned not only about communicating regularities but also oriented towards specific expectations of post-discharge durations in their accounts. These were

remarkably consistent such that it was possible to determine an expectation that a period of 5 years post-discharge was required before one might expect to achieve unconditional discharge. The important caveat expressed by many patients was that this period must be free from any evidence of relapse or risk behaviours associated with mental distress. Workers however emphasised in their accounts that time passing and absence of risk behaviours were just parts of a judgement that included subjectivities such as whether the patient was "open and honest" (Keith's CPN) in their dealings with the care team. Regularities were nevertheless clearly emphasised by workers as a form of practice routine. In the following extract the Community Psychiatric Nurse (CPN) working with Tony indicated that set temporal routines were applied at least initially to everyone leaving hospital on conditional discharge. The CPN however made a comparison with another patient, John, to show that awareness of "possibilities", meaning possible risk behaviours, informs aftercare decisions.

> P:….we always do tend to provide a lot of input when people do go out. The contact wouldn't have been any different but with [John] we would have been more aware of the possibilities with [John] than with [Tony]. We do tend to see people weekly in the first 3 months so they get quite a lot of contact, they see myself, a social worker and the [doctor] every week up until the first review and that's done with everybody we discharge.
>
> (Tony's CPN: Setting 1)

Regularities once identified also allow patients to negotiate changes to aftercare supervision and eventually to bargain towards full and unconditional discharge. Keith, who had been detained for more than 8 years in both prison and forensic psychiatric settings, indicated his intention to engage in a process of bargaining and negotiation with the authorities to achieve complete discharge in line with the above timetable.

> P: I worked for a long time really hard and even now you know you're talking about I've been put away for 8 and half years, I have been out for 3 and half years, so 12 years of my life and every week they come and they've got to make sure I'm okay and things like that and it just gives you stress and I told them each time I have a meeting it's stress, each time I've got to go up to [hospital] it's stress so I'm getting ready this year now umm to put in for a tribunal to come off restrictions, because I think you know if I don't come off them this year I can say well what work must I do and next year I can come off them. It's going to happen, it's inevitable. I've proven that when I go there
>
> (Keith: Setting 2)

Keith's account accomplished the moral patient who has "worked" hard and shown his suitability for full discharge by following the guidance of those working with him. He constructs this "work" in the form of regular meetings and assessments by the clinical team

as stressful. The duration of this aftercare was therefore to be seen as taking its toll on him and he was preparing to negotiate to effect his full discharge.

Workers described the use of aftercare supervision in a different way. They portrayed these schedules as managed risk-taking, that is, it allowed greater levels of freedom to assess how well the person performed the rehabilitative tasks necessary to maintain community living. The assessment by workers of the success or otherwise of aftercare supervision was an important determining factor in decisions to alter schedules.

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). In the following extract an example of this can be seen in the clear mismatch between Keith's expectations outlined above and that of the social worker who is responsible for his supervision.

> P: …it's not easy for 37/41 clients because they know that there's another layer, you know there's the law thing, there's the conditions and they are set down in law and it's not conditions we're putting on him, so they know where they are and if he, I mean I think that's what keeps him where he is. He's not one of those I would recommend to come off 37/41 (2) in a way it helps him to know that that's the boundary there.
>
> (Keith's Social Worker: Setting 2)

**TIME AND DIRECTIONALITY**

Discontinuities implicate a concern with other time relevant qualities of accounts such as benchmarking, delays in schedules and directional narratives. The very nature of these accounts signal identity relevant time claims such as time passing, lessening of risk and reducing levels of supervision and monitoring. In telling stories of deviance event categories participants show that these were temporally bounded episodes, occurring in the past and therefore no longer immediately identity relevant.

Although conditional discharge is indeterminate, and formal timetables do not exist, there remain opportunities for patients and workers to benchmark experiences against others following the same process. In effect this means that both patients and workers sift details of similar cases to establish benchmarks for possible lessening of supervision and movement towards complete discharge. It is also possible that there may be mismatches in benchmarks established by workers and those of patients. Nevertheless regularities become important resources for patients in demonstrating distance from past labels while

irregularities become relevant sources for complaint. For workers however time is just one part of an equation that includes their assessment of the risk embodied by the patient.

Benchmarking

The process of detention and restricted discharge in forensic settings provides ample opportunities for patients and workers alike to establish timetables for multiple steps towards lessening of supervision and eventual liberty. Patients effectively create new social networks in which their movement through various stages of supervision is compared to others in terms of timed phases of progress. In the following extract Tony compared his stay in medium security against others purely on time served rather than any other measure of progress.

> P: …I was only in for a short, I was in for about just 2 and half years just over 2 years I think. (2) So compared with some, the others they have been in the system 5 or 6 years some of the youngsters innit and they haven't got a chance in hell in my opinion.
>
> (Tony: Setting 1)

That patients focus on time is perhaps not surprising. They do not have access to the intricacies or idiosyncrasies of decision-making processes of workers. Time is a direct and much more tangible measure despite its evident lack of sensitivity. Benchmarks allow determinations of progress but also signal morally favourable states as they can be used to show movement towards ordinary identities. In this extract Tony achieved this by indicating that he saw his detention as 'short' and then moved to compare the actual time with others. This functioned to show that Tony was different and perhaps too on an express route away from the previous stigmatised identity of mentally ill person and offender. Tony showed concern about this identity throughout his interview indicating that he was "different", had changed his name, moved to a new area on discharge and was concerned what his neighbours might know about him. Determinations of benchmarks are likely to be more nuanced than simply being based on measures of time. Roth (1963) has previously shown that patients self-categorise based on an understanding of norms for subgroups within the patient body. It is then possible to see if one is ahead of schedule or behind and to make adjustments to expectations related to trajectory. Schedules can be delayed or setback for a number of reasons. One reason for delays was related to a failure to follow established rules that furnished access to established discharge timetables.

"I kicked the system": Explanations for delays and setbacks in schedules

Delays and setbacks in timetables can occur at any stage of the process of contact with the forensic psychiatric system. This includes decisions made in court on the

possible destination for convicted persons where the Mental Health Act has been applied. In such circumstances delays are largely unforeseen by the patient. With the benefit of hindsight many see that alternatives such as prison sentences would have brought with them set tariffs, less time detained and clearer termination of official follow-up by workers. Patients are, at least initially, largely unaware of timetables used in forensic psychiatry and workers are not keen to be pinned down to a schedule until they learn more about the person and their risk status. Bryn indicates as much in the following extract.

> P: ….I got it wrong but this is what I felt then naively in '95. The 41 will open those doors for me make people take notice of the fact that I have got a condition, I need to be seen. (1) And it's a boundary you know it's like a fence you know I had no intention of stepping outside that 41 fence. I felt that being within the fence I'd get more support you know. All it does is get you locked up quicker (1) and longer, with a 41 you're seen as a more dangerous person on the 41 you see. I've been on them all over the years, section 3, 37 you know all them. They put the 41 on me and like you know anything to do when you're in hospital it takes longer (1) you know.
> I: slows everything down?
> P: most definitely yeah most definitely. You know there are people who need to be on it for life, there is other people who who don't need to be on it for life. There are people like myself who when they get a little bit manic need to come in informal. They don't need to be recalled costing you money and everybody else money and taking up beds that other people should be in who are ill you know so I mean that's important too to note …I mean I didn't break no law.
>
> (Bryn: Setting 2)

Bryn indicated his 'naïve' view that a mental health disposal in court would get him the help he had long requested. His conclusion however was that unforeseen consequences emanating from this decision had led to a lower threshold for recall to hospital and longer periods of detention. Bryn uses his account to do the moral work of the patient seeking help but subject to the vagaries of a mental health system more attuned to risk aversion than therapeutic intervention and social support. His complaint, summed up with "I didn't break no law", was that a Mental Health Act disposal had ultimately highlighted him as a risky individual in need of prolonged supervision. Bryn drew a comparison between "people who need to be on it for life" and himself. In doing so his complaint worked to establish his difference from those who need lifetime supervision. Delays in his recovery schedule were then presented as outside his control and costly in terms of resources.

Louise indicated that setbacks in achieving discharge can result from a failure to follow rules thus causing delays in the timetable for release.

P: ..I kicked the system for years see and that's why I think they kept me in so long. ….
I: when you say you kicked the [system
P: yeah] I did, fought the system, I went in in umm eighty, eighty-one, I could have been out three years later (2) just didn't work that way.

(Louise: Setting 1)

Delays in timetables extend into the community when the person leaves hospital on conditional discharge. Expectations of duration of post-hospital follow-up and monitoring can be upset by interruptions caused by mental ill-health or recurring risk behaviours. These accounts functioned as salutary lessons of what might come to pass and were based on hard won experience. Potential interruptions however also extend into the future as the threat of recall to hospital is presented as a further interruption to recovery trajectories. Recall to hospital also implicates identity as it brings the past into the present and refreshes deviance labels of mental illness and dangerousness.

I: The concern is that it makes you more risky I suppose.
P: But the thing is you see it's a long time ago see, this is why I don't like it. You're looking like the index offence now is nearly 15 years ago and I'm still on section …. But that was 15 years ago, that was a long time ago that is you know.

(Iestyn: Setting 2)

Iestyn refuted the suggestion put to him that the concern of workers about his use of illicit substances related to his riskiness by challenging the idea that his behaviour of many years ago was relevant to his current situation. In doing so Iestyn used time to create significant distance between past and present identities and indicated that he should not be sanctioned on the basis of his history.

History weighs heavily in the present for forensic patients and workers alike. Many accounts from participants located interruptions in the past. Accounts of hospital living and discharge were then used to communicate a sense of an ever-improving situation in relation to living circumstances, the amount of supervision required and the mental health condition. The phased nature of conditional discharge was evident in Niall's account which was organised to achieve a positive directional narrative of his move from supervised living towards the relative independence of renting his own flat.

P: Yeah, umm (1) what it was, when I first came here it was on the understanding that umm I didn't I wasn't going to have to stay here very long. … because I'm on a 37/41, they said right we'll umm we'll follow you up for six months initially and then we'll hand you over then to [local hospital] … (3) so I was told that I you know I would only probably stay here six months and if it was probably anywhere else it would have only been six months but I've been having the life of Riley here you know, it's been good. So I had a umm a CPN, social worker, I seen the consultant once every couple of months, 117's [meetings held to plan and review aftercare as required under the Mental Health Act 1983 for all detained patients] which I still see now but I had it from the [forensic hospital] for

six months and after that then it was [local hospital] like. And all that's going to change again after next week so.

(Niall: Setting 2)

In this extract Niall followed-up his complaints about discontinuities with a 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. This transfer of care was presented as evidence that he was no longer in need of the same level of post-discharge scrutiny. Niall used his account to telescope time post-discharge as a way of foreshortening the duration of aftercare and perhaps to construct the case for its early termination. Time was also an important signifier of rehabilitation and movement to levels of more independence. The longer interval spent in supervised accommodation which might imply untoward or unexpected needs for continuing care was resolved 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 Niall that all was about to "change again after next week" when he was due to move to the 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. In doing so Niall accomplished the task of presenting himself as a moral entity by virtue of his steady conformity to set rules which was to be rewarded with increased opportunities to distance him further from previous labels.

This view of time as an important signifier of the rehabilitative process was also evident in the interview talk of Niall's workers. 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.

P: I have in my memory and I can't check that but it may have been the full 6 months before [Niall] was handed over or it may have been slightly shorter than that (2) and I think in one sense we always from the beginning we found [Niall] (2) <u>thought</u>-provoking I think. He actually worried us (2) but because he is actually <u>so</u> incommunicative. (8) [sighs] […]He also umm almost as soon as the [medium security unit] stopped (1) their supervision, he actually wanted to reduce the visits (2) to monthly (3) which we felt was much too soon for somebody who'd only been out of medium secure for six months (2) umm and we managed to achieve a compromise with that. We in fact said no we have to carry on seeing you fortnightly in fact some people would argue that a 37/41 should be seen weekly (2) umm we have to see you fortnightly but we offered him a <u>six</u> weekly outpatient appointment with the RMO [Responsible Medical Officer] (2) rather than a monthly one. Umm [drinks her coffee] which is I think

we sort of achieved a satisfactory compromise with that.

(Niall's social worker: Setting 2)

The social worker's account shows that time was an important criteria in expectations of post-hospital supervision of risky individuals. The 'full six months' in one sense works as a proxy for the absence of more objective judgements of risk and need for ongoing monitoring. It is however a somewhat blunt instrument and the worker is oriented towards this, showing that more subtle but perhaps equally subjective evaluations are made based upon the unsatisfactory nature of Niall's communication with the team. For workers it seems time is a necessary requirement of post-hospital supervision but insufficient in itself, at least initially, as a means to reach judgements of reducing the intensity of aftercare.

**DISCUSSION**

Lyman and Scott (1970:189) have noted that "social and cultural conventions carve out time segments from the raw, existential world" creating complex and multiple 'time tracks' for human existence. In this paper I have focused upon a particular subset of the available time tracks that are experienced by people leaving forensic settings and the workers who monitor and support them. There are of course may other time tracks including illness career journeys, chronological age and experiences of various cultural eras which many participants will have known. In seeming to neglect other temporal events this paper does not imply they are of less importance but rather the intention is to focus upon those temporal aspects that participants themselves made salient in their accounts.

The indeterminate nature of section 37/41 designations implicates and directs attention to temporal considerations by workers and patients alike. Forensic patients on conditional discharge differ markedly from other groups such as prisoners in this respect. Prisoners on the whole are released with little follow-up surveillance and as a result may have opportunities to shake off deviance labels in ways that forensic patients cannot due to their regular and intense supervision (Shinkfield and Graffam, 2009). The flip side of this however is that conditionally discharged persons show a 7% recidivism rate within two years of discharge (Ministry of Justice 2010) compared with 39% reconviction rates of those released from prison (Ministry of Justice 2011). Caution needs to be applied interpreting these figures as the rates for discharged mentally disordered offenders do not include all those released. Nevertheless it appears to be the case that released prisoners fair less well than patients from forensic settings suggesting that supervision and planning of aftercare play an important role (Visher and Travis, 2003).

Temporal unpredictability caused by the indeterminate nature of the discharge conditions

may prompt individuals to begin the task of constructing new identities by mobilising particular resources in their talk of aftercare. These resources include notions of benchmarking and directionality. 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, for patients 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.

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 across time. The presence of directionality within temporally bounded narratives can then be read as an identity function. Stories of movement towards discharge from hospital to home and ultimately reductions in monitoring were used to indicate progressive directionality and as such are an important feature in identity work in talk of discharged forensic patients.

Although there may be other potential narratives that the person can employ to achieve identity work, Gergen and Gergen (1983) argue that for cultural reasons these are limited to set repertoires, for instance for reasons of social utility. One example can be seen in the use of vocabularies of motives to explain actions (Mills 1940), which appear in talk under particular conditions such as when called upon to offer accounts which aim to persuade or dissuade imputations in interaction. Research interviews 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 settings, narrative repertoires centre on progressive accounts albeit with numerous disruptions. The temporality of these narratives function to place the person within the wider social sphere, assert particular identities and establish claims to directionality. Directionality in the talk of the conditionally-discharged may then function to show movement from previous illness identities towards newer identities of recovery. The use of time in these accounts helps to establish identities as mutable and dynamic, always in play and with the potential to shed previous versions.

The focus on time passing is one element of the way in which participants accounted for movement through the system. Pace and sequencing of post-discharge phasing must be negotiated between parties in aftercare arrangements. If the pace of arrangements for moving between stages of post-discharge supervision is too fast or the sequencing doesn't meet the risk management needs of workers then it will not be supported by them. Mental Health Review Tribunals may still subvert workers priorities and patients were aware of the possibilities in this regard especially when the pace of movement through stages was considered too slow. Where the pace or sequencing of arrangements were not supported by patients then these become a source of complaint and dissatisfaction (Coffey 2011). In addition to temporality workers indicate parallel processes of assessment of potential future risk behaviours. Service-users placed less emphasis on risk behaviours 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 (Monahan, 1988). Workers frequently implied that achieving accurate understandings of potential risks was something that would emerge over time.

Once discharged, it can be seen that patients continue to work to establish regularities with regard to timing of phases of aftercare monitoring. A number of participant's stories retell events in which they sought to negotiate with staff to establish timetables for leaving hospital, phasing of ongoing aftercare or reduction and termination of supervision. Others compared themselves with people who had successfully achieved full discharge, as a way of determining an approximation of how long aftercare would continue. Workers' accounts prioritise concerns about risk as a means to establish direction and speed of movement towards less supervision (Heyman et al, 2004). These accounts suggest benchmarking by both workers and patients, in which normative temporal ordering of the social world is devised in interaction (Bergmann, 1992). Mismatches in schedules were highlighted in research interviews and suggest that these are important sites for ongoing negotiation between patients and workers. The stories of participants functioned to show the achievement of incremental improvements along the path towards the establishment of new identities (Roth, 1963).

An emphasis on directionality is however 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. Accounts can be seen to do the work of aligning oneself with others who progress smoothly through the system of care and in contrast to those who experience delays or who make little progress. This works to

counter the concern that a claim to a particular social identity may not be substantiated due to an association with people who are negatively evaluated (Snow and Andersen 1987). Claims to newer identities were 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.

Where delays were encountered patients used their accounts to indicate where they saw the responsibility for this. Delays may be regarded as timetable failures by both patients and workers as they indicate a breakdown in progress towards recovery as implied by available benchmarks. Timetable failures violate expectations and as such there is an imperative to account for them. Kicking against the system ostensibly locates responsibility for delays with the person but it also indicates personal agency and invokes visions of rigid inflexible care systems that are unable or unwilling to adapt to the needs of the individual. Asserting agency in highly controlled circumstances allows patients to harness events to their own ends, if only temporarily. Discontinuities are therefore handled by patients to accomplish agency and furnish nascent identity work. More generally, for patients discharged from forensic settings temporal explanations do important work. They function to create distance from previous deviant acts and show a concern to establish transition to ordinary identities.

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## TRANSCRIBING CONVENTIONS

| | |
|---|---|
| [drinks coffee] | description of participant action or substituted name |
| over[lap | square brackets between adjacent lines indicate beginning and end of |
| overlap] | 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 |
| I: | Denotes interviewer |
| P: | Denotes participant |

**REFERENCES**

Adam, B. (1990) *Time and social theory*. Cambridge. Polity Press.

Bergmann, W. (1992) The problem of time in sociology: An overview of the literature on the sate of theory and research on the `sociology of time', 1900-82. *Time & Society,* 1(1), 81-134.

Braun, V. & Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology,* 3, 77-101.

Bury, M. (1982) Chronic illness as biographical disruption. *Sociology of Health & Illness,* 4(2), 167-182.

Cairney P. (2009) The 'British policy style' and mental health: beyond the headlines. *Journal of Social Policy,* 38, 671-88.

Clarke, L. (1996). Participant observation in a secure unit: care, conflict and control. *NT Research, 1*, 431-440.

Coffey, M. (2011) Resistance and challenge: Competing accounts in aftercare monitoring. *Sociology of Health and Illness.* 33(5): 748-760.

Coffey, M. (2012a) 'A risk worth taking? Value differences and alternative risk constructions in accounts given by patients and their community workers following conditional discharge from forensic mental health services *Health Risk and Society* 14(5): 465-482

Coffey, M. (2012b) Negotiating identity transition when leaving forensic hospitals *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine* 16: 489-506.

Dell, S., & Grounds, A. (1995) *The discharge and supervision of restricted patients*. Report to the Home Office. Cambridge. Institute of Criminology University of Cambridge.

Edwards, D. & Potter, J. (1992) *Discursive Psychology,* London. Sage Publications.

Garfinkel, H. (1967) *Studies in ethnomethodology*. Englewood Cliffs, New Jersey. Prentice-Hall.

Gergen, K. J., & Gergen, M. M. (1983) Narratives of the self. In *Studies in Social Identity* (Ed, Sarbin, T. R., & Scheibe, K.E.) pp. 254-273. New York. Praeger Publishers.

Goffman, E. (1963) *Stigma: Notes on the management of spoiled identity,* New Jersey. Prentice-Hall Inc,

Hannigan, B. and Coffey, M. (2011) Where the wicked problems are: The case of mental health. *Health Policy,* 101:220-227.

Heaton, J. (2001) Hospital discharge and the temporal regulation of bodies. *Time & Society,* 10(1): 93-111.

Heyman, B., Shaw, M. P., Davies, J. P., Godin, P., & Reynolds, L. (2004) Forensic mental health services as a risk escalator: a case study of ideals and practice. *Health, Risk and Society,* 6(4): 307-325.

Hyden, L. C. (1997) Illness and narrative. *Sociology of Health & Illness,* 19(1), 48-69.

Klitzman, R. (2007) "Patient-time", "doctor-time", and "institution-time": Perceptions and definitions of time among doctors who become patients. *Patient Education and Counselling,* 66(2): 147-155.

Lowman, J., Menzies, R. J., & Palys, T. S. (Eds.). (1987). *Transcarceration: Essays in the sociology of social control*. Aldershot: Gower.

Lurigio, A. J., Fallon, J. R., & Dincin, J. (2000). Helping the Mentally Ill in Jails Adjust to Community Life: A Description of a Postrelease ACT Program and Its Clients. *International Journal of Offender Therapy and Comparative Criminology, 44*(5), 532-548.

Lyman, S.M., & Scott, M. B. (1970) *A sociology of the absurd*. New York. Appleton-Century-Crofts.

Manning, N. (2000). Psychiatric diagnosis under conditions of uncertainty: personality disorder, science and professional legitimacy. *Sociology of Health and Illness, 22*(5), 621-639.

Mills, C. W. (1940) Situated actions and vocabularies of motive. *American Sociological Review,* 5(6): 904-913.

Ministry of Justice (2010) S*tatistics of Mentally Disordered Offenders 2008 England and Wales Ministry of Justice Statistics bulletin*. London: Ministry of Justice.

Ministry of Justice (2011) *Adult re-convictions: results from the 2009 cohort England and Wales. Ministry of Justice Statistics bulletin.* London. Ministry of Justice.

Monahan, J. (1988) Risk assessment of violence among the mentally disordered: generating useful knowledge. *International Journal of Law and Psychiatry,* 11: 249-257.

Nolan, P., Bradley, E., & Brimblecombe, N. (2011). Disengaging from acute inpatient psychiatric care: a description of service users' experiences and views. *Journal of Psychiatric and Mental Health Nursing,* 18(4): 359-367.

Pilgrim D, & Ramon S. (2009) English mental health policy under New Labour. *Policy & Politics,* 37: 271-88.

Roth, J. A. (1963) *Timetables: structuring the passage of time in hospital treatment and other careers,* Indianapolis: Bobbs-Merrill.

Scott, M. B., & Lyman, S.M. (1968) Accounts. *American Sociological Review,* 33(1): 46-62.

Shinkfield, A. J., & Graffam, J. (2009). Community Reintegration of Ex-Prisoners. *International Journal of Offender Therapy and Comparative Criminology, 53*(1), 29-42.

Skelly, C. (1994) The experiences of special hospital patients in regional secure units. *Journal of Psychiatric and Mental Health Nursing,* 1(3): 171-177.

Snow, D. A. & Andersen, L. (1987) Identity work among the homeless: The verbal construction and avowal of personal identities. *The American Journal of Sociology,* 92(6): 1336-1371.

Strauss, A., Schatzman, L., Ehrlich, D., Bucher, R., Sabshin, M. (1963) The hospital and its negotiated order. In: Freidson, E. (Ed.), *The Hospital in Modern Society*. pp. 147-169. New York: The Free Press.

Thomas, J. (1984) Some aspects of negotiated order, loose coupling and mesostructure in maximum security prisons. *Symbolic Interaction* 7 (2), 213-231.

Torre, R. R. (2007) Time's social metaphors: An empirical research. *Time & Society,* 16(2-3): 157-187.

Visher, C. A., & Travis, J. (2003). Transitions from prison to community: Understanding individual pathways. *Annual Review of Sociology, 29*, 89-113.

Zerubavel, E. (1976) Timetables and scheduling: on the social organization of time. *Sociological Inquiry*. 46(2): 87-94.