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From Pathological Dependence to Healthy Independence: An emergent grounded theory of facilitating independent living

Liz Jamieson, Ph.D; Pamela J. Taylor, F Med Sc; Barry Gibson, Ph.D.

Abstract

People with mental disorder are admitted to high security hospitals because of perceived risk of serious harm to others. Outcome studies generally focus on adverse events, especially re-offending, reflecting public and government anxieties. There is no theoretical model to provide a better basis for measurement. There have been no studies examining discharge from the perspectives of those involved in the process. This paper begins to fill this gap by generating a grounded theory of the main concerns of those involved in decisions to discharge from such hospitals. Data were collected by semi-structured interviews with staff of various clinical and non-clinical disciplines, some with a primary duty of care to the patient, while mindful of public safety, and some with a primary duty to the public, while mindful of patients' rights. The data were analysed using a grounded theory approach. Their main concern was 'pathological dependence' and that was resolved through the process of 'facilitating independent living'. Clinicians and non-clinicians alike managed this by 'paving the way' and 'testing out'. The former begins on hospital admission, intensifies during residency, and lessens after discharge. Testing out overlaps, but happens to a greater extent outside high security. Factors within the patient and/or within the external environment could be enhancers or barriers to movement along a dependence-independence continuum. A barrier appearing after some progress along the continuum and ending independence gained was called a 'terminator'. Bad outcomes were continuing or resumed dependency, with 'terminators', such as death, re-offending or re-admission, modelled as explanations rather than outcomes per se. Good outcomes were attainment and maintenance of community

living with unconstrained choice of professional and/or social supports. Although this work was done in relation to high security hospital patients, it is likely that the findings will be relevant to decision making about departure from other closed clinical settings.

KEYWORDS: pathological dependence, independent living, grounded theory, mentally disordered offenders, high security (special) hospitals

Background

Most countries have special secure healthcare facilities for people with a major mental disorder thought to pose a serious threat of harm to others, generally after at least one serious criminal conviction. It is difficult, however, to compare outcome studies between different countries because laws, policies, social structures and service availability may each vary widely. Facilities may be entirely within the health services, entirely within prisons, or a mixture of the two. Not all countries provide every level of security, and there may be international differences in definitions of 'high', 'medium' and 'low' security. There is, though, common ground in being held in such a secure institution - in constraints to freedom and autonomy within and outside the unit and long enforced proximity to others with grave health and behavioural problems. In England and Wales, people with a major mental disorder, detainable under mental health legislation and thought to pose a high risk of serious and imminent harm to the public, may be admitted to a high security, or 'special' hospital. Median length of stay there is over six years (Butwell, Jamieson, Leese & Taylor, 2000).

Perhaps the most common ground to date between studies internationally and over time is in choice of outcome measures. Studies in both the United Kingdom and North America, for example, have focused almost exclusively on re-offending (Jamieson & Taylor, 2004; Steadman & Keveles, 1972; Steadman & Cocozza, 1974; Thornberry & Jacoby, 1979; Pruesse & Quinsey, 1977). There is less common ground between nations, however, in definition of offences and base rates of crime, both important to making sense of this type of outcome (SWANZDSAJCS, 2006). Russo (1994), who studied such discharges in Barcelona, Norris (1984) and Steels, Roney, Larkin, Jones, Croudage & Duggan (1998), who studied them in England, also examined mortality

Self Pacing

The process of finding the right balance between theoretical sampling in the field and the reading of literature took time. It challenged me to test out a variety of working methods and being extremely flexible when planning the daily work. When concentrating only on field data for longer periods of time, I became locked in my own thinking. And vice versa; if I became caught up in reading other theorists' works, my own analytical process was blocked. Sometimes I just became overwhelmed by the endless amount of relevant research, and really had to fight to get sufficiently grounded in empirical data to be able to proceed.

The testing out exemplifies the necessity of theoretical pacing, self-pacing and the development of a personal pacing plan when generating grounded theory (Glaser 1978). Grounded theory not only requires joint action when collecting, coding and analyzing data. It requires that the analyst knows his own temporal pacing and manages to develop a personal plan that takes his research into consideration as well as his temperament and private life.

As a methodology, grounded theory provides the analyst considerable autonomy and freedom to pursue his own study under a great variety of structural conditions. The experience during this particular study is that theory generation is such an absorbing and time-consuming project that it needs to be well paired with other aspects of the analyst's daily life in order to work out. Grounded theory takes the time it takes, and it is hard to make an accurate estimate of the time needed. Restrictions on outer frames must of course always be taken into consideration. But within such frames the analyst is dependent upon finding his own plan so that he can establish realistic deadlines and make continuous progress.

Since grounded theory is above all what Glaser terms a delayed action phenomenon, I experienced that it is very important to set aside enough time for subconscious processing. When data is sampled, coded and analyzed, memoing is the helper that attends immediate to all kinds of ideas that might arise as a result of the previous work. Sometimes a concept appears several months or even years after the analyst started working on it. At other times, conceptualization just goes on and

and simple social indicators, such as return to families.

The tendency to focus on adverse events reflects social and political concerns with re-offending. No health care worker wants to be associated with repetition of a serious offence. These concerns have led to an increase in the use of risk prediction tools, although, in prospective studies, even actuarial measures of risk prediction have been shown to perform at about chance levels (Buchanan & Leese, 2001). Attempts to 'allay public anxiety through legal measures have been finely balanced against professional medical opinion' (Symonds, 1998), and remain controversial (Joint Committee on the Draft Mental Health Bill, 2005).

Government responses to a single, rare tragedy often seem to shape the manner in which discharge from high security hospital units is considered. There has been very little attempt, however, to understand the perspectives of those who are active in deciding on discharge, and neither the process nor its evaluation is theoretically driven. It was with this in mind that one of us (LJ) started to consider generating a theory centred on the main concerns of staff involved in the discharge process. A grounded theory approach (Glaser & Strauss, 1967) was chosen. Concerns exist for both the people detained and the people effecting the detention or release from detention. We accept that each might have a different perspective, and we acknowledge the lack of secure hospital service user input as a possible limitation on the theory generated. The reality is, however, that for this group of hospital patients the departure and discharge decisions are made by the sort of people interviewed rather than the patients/service users themselves. On this basis it was considered important to focus on the decision makers.

Method

Ethics Committee approval

This research was approved by the West London Mental Health Trust's Ethics Committee and formed part of the doctoral thesis of the first author. Each interviewee was provided with an information sheet which explained the purpose of the study, together with a consent form to sign, on agreement that his/her data could be used. Signed consent was obtained for every direct quotation that has been included and selected quotations were all validated by the respondents themselves. Four interviewees

wished to clarify or amend certain quotations and this was done in consultation with them. Two quotations which the respondents subsequently considered were inaccurate were withdrawn.

Sample selection

There was no pre-determination of sample size. Its nature was defined by the requirement that participants should have some kind of role with respect to the outcome and rehabilitation of serious offender patients. The candidates for the sample were initially selected on the basis of their capacity and potential for providing data on different aspects of the research question. Thus, as the task was to develop a substantive theory according to the main concerns of professionals about discharge from high security, there was a requirement that the candidates for the sample had knowledge of the hospitals, the full range of other relevant services, their residents and, in general terms, possible outcomes after discharge. Variation in level of security (low, medium and high) in which they worked was sought deliberately, as Glaser & Strauss (1967) suggested that categorical development is slower in a single location. Theoretical sampling helped to maximise the differences in the data and saturate the categories. For instance, participants who would enable variety in perspectives by virtue of training or disciplinary background, or their position in the before and after discharge spectrum (the position of recommending, promoting, or determining discharge or of receiving or observing the discharged patient) were selected.

The final sample was made up of forensic psychiatrists (7) with a range of experience and from a variety of secure settings, a nurse manager, a nurse employed to facilitate transfer of patients, a psychologist, social workers (2), psychotherapists (2), education staff (2), Home Office Mental Health Unit civil servants (3) and a specialist mental health lawyer.

Characteristics of the participants

The first interviewee, who was chosen arbitrarily, was a consultant forensic psychiatrist. The next was chosen from the same professional group to see whether there was within-discipline variation. Participants were interviewed thereafter according to constant comparative analysis. They were from various disciplines and settings. The point at which saturation of categories occurred and there was a high degree of theoretical

integration between categories was after 20 interviews. Fifteen had been with men and 5 with women. Their length of experience ranged from a few months working directly with special hospital patients, to over 20 years. Thus, the sample included clinical and non-clinical respondents, those whose clientele was explicitly made up of patients while mindful of public safety, and those whose clientele was the public, while mindful of individual patient rights, those with long experience and those with relatively little, and people who had had minimal or maximal contact with special hospital patients. Details of the participants are shown in Table 1. Names have been changed for the purposes of anonymity. Gender-appropriate, but false, names have been given to interviewees.

Table 1 Summary of characteristics of participants

Name	**Sex**	**Occupation**	**Location in the discharge process**
STEPHEN	M	Psychotherapist	High security hospital
MICHAEL	M	Forensic Psychiatrist	High security hospital
SIMON	M	Forensic Psychiatrist	High security hospital
STEWART	M	Psychotherapist	High security hospital
LUKE	M	Forensic Psychiatrist	Other inpatient health service
MARY	F	Administrative/ clerical	Community
EDWARD	M	Forensic Psychiatrist	Community
HARRY	M	Forensic Psychiatrist	High security hospital
SAM	M	Administrative/ clerical	Community
BRUCE	M	Administrative/ clerical	Community
MELISSA	F	Psychologist	High security hospital
NEIL	M	Forensic Psychiatrist	Other inpatient health service
ANGELA	F	Nurse Manager	High security hospital
SUSAN	F	Mental health lawyer	Community
MARTIN	M	Education staff	High security hospital
BOB	M	Occupational therapist	High security hospital
KEVIN	M	Social Worker	High security hospital

FRANK	M	Social Worker	High security hospital
PENNY	F	Nurse involved in the transfer of patients	High security hospital
JOHN	M	Forensic Psychiatrist	Other inpatient health service

Data collection

Data were collected over ten months from semi-structured interviews. Each participant was interviewed once. Outcome of discharge has typically been measured over long periods of five, ten or more years. The research question was: 'Please will you describe your experiences and knowledge of discharges over a period of about 10 years' follow up?' The interviews were open ended and participants were encouraged to speak openly and freely. Our theoretical interest was in their principal concern with discharge. Shorthand notes were made by the researcher during the interview, and typed up in full immediately, or up to 24 hours later in all but two cases (which were completed within 48 hours).

Data collection ceased when there was a high degree of theoretical integration of the concepts and the data collected provided no new insights to advance the theory. Saturation was tested by continuing to look through the remainder of the data set, returning to what seemed the most divergent examples within the sample, looking for negative cases which did not fit with the theory.

Data analysis

The data were coded line-by-line using a process called open coding, in which each datum was inspected to generate categories and their characteristics from particular indicators. Key words and phrases that captured the essence of the data were used for the categories, and noted on the margins of the transcripts. These categories were not mutually exclusive, so one category could be illustrated by many indicators or incidents in the data. Data were examined for similarities, differences, and consistencies (Glaser, 1978; Glaser & Strauss, 1967). Each category was considered in terms of its dimensions or characteristics. Questions were asked such as: 'what category or property of a category does this incident indicate?' Each new instance (indicator) was compared to other instances and to

categories as they emerged, using the process of constant comparative analysis. Thus dimensions of categories came from the data rather than being logically deduced or forced from previous theory and these emergent distinctions made the concepts rich and sensitive in explanatory power.

During the process of selective coding, important categories were collapsed into a list of more general categories, or, in Glaser's terms, substantive codes. All subsequent transcripts were coded using these categories, and text excerpts were gathered under each category to show the range of variation within each substantive code. The decisive criterion for the core category was that it could encompass and explain the area of interest, namely, the main concern regarding discharge of special hospital patients. Inter-relationships of all categories to the core category were considered.

Records of data collection and analysis were kept in the form of memos, informal notes on the conceptualisations that emerged from each coding session and which served as the building blocks of the theory. Near the end of the analysis, memos were sorted on the conceptual level, which put fractured data back together and was the key to formulating the theory.

A literature review was not conducted until after the substantive theory was formulated. PsychINFO (supplied by OVID) and Medline were then searched for "Grounded Theory studies", "independence/ independent living", "rehabilitation" and "community /community care". The literature was then integrated into the theory.

Results

The core concern

In this study, the main concern centred on movement between pathological dependence and healthy independence. Participants consistently raised themes of 'dependence' and 'independence', with comments about the ideas often entangled, for example: 'Dependence in our society influences everybody – financial, work, relationships. They [the patients] are disadvantaged in all three areas.' (Susan1, 3.12.02, Clinical Psychologist). Pathological dependence was influenced by support. The greater the amount of personal support someone could secure by his or her own efforts, the greater the degree of

independence that would be attributed to him or her, with acknowledgement of the paradox in 'healthy independence', incorporating mutuality and choice about dependencies and reciprocities in relationships: 'Well, none of us lives independently. We should be encouraging people to use networks – social services, support groups. They need to actively engage' (Mike, 07.02.03, Occupational Therapist (OT)) and 'Everyone is supported by others. Having other people you can relate to and managing an independent environment…you would have a community mental health team. Support. But they would still be living in the community' (Paul, 10.02.03, Social Worker (SW)). Community, however, is a nebulous concept, often evoking scepticism and masking conflicts (Leff, 2001). Entanglements appear in the literature too. A community may exist within an institution (Wing, 1990), even a secure institution. Nevertheless, there is usually a gap between a 'made' therapeutic community, which even in high security may achieve a measure of democracy and flattened hierarchies, and the community inhabited by the wider public, which often demands separation and protection from the very people health care professionals are hoping to integrate within it (Symonds, 1998). There is therefore often a conflict between the need for greater therapeutic independence versus public reflections of the need for protection.

Pathological independence sometimes occurred by default. 'Default independence' occurs, for example, when a patient's detention order is absolutely discharged by a Mental Health Review Tribunal. 'They have been discharged because they are untreatable, not because they are safe. When patients are conditionally discharged, they have conditions - after absolute discharge there is no statutory requirement for supervision' (Helen, 11.10.02, Non-Clinical). 'Absolute discharge' most usually happens for those detained under the legal category of 'psychopathic disorder' or 'mental impairment'. For both, there is a requirement under present mental health legislation for England and Wales that "such treatment is likely to alleviate or prevent a deterioration of [the patients] condition", and if it is determined that this is not the case, the patient must be absolutely discharged from the treatment/hospital order. The concept of treatability was further clarified in Cannons Park. Absolute discharge generally means that the patient returns directly to the community without supervision. Services can and often do cease to offer anything to such people, who, in turn,

rarely choose to attend services consistently. One feature of pathological independence is being unable to make appropriate use of services and/ or not being able to access them at all, then frequently returning to pathological dependence. 'PDs (patients under the legal category of psychopathic disorder) get "stuck" in security or discharged via Tribunal to the community and fare less well' (Tom, 18.10.02).

The hospital was generally construed as a place of dependency, providing safety or asylum as well as of constraint, and the community, for various reasons as less safe, supportive or protective, therefore demanding different qualities in dependency. For example: 'Special hospitals also provide drugs, therapy, absence from drugs' (William, 03.01.03, CFP). Years of dependence on a protective environment and supervising and treating staff were seen as threatening to leave the patient unable to resolve his or her potential for pathological dependence: 'Patients are scared of freedom and their potential. They need to acclimatise, being seen as different, looking different, being tattooed, looking like they are on medication, not fitting in, not having support networks, food changes, routine, cars drive faster than 10 years ago' (Susan, 12.12.02, Clinical Psychologist).

The participants sometimes spoke of dependence simply in terms of the opposite of independence. They identified three main markers of independence: financial, functional and emotional, including the ability to form reciprocal relationships. Treatment for pathologies of dependence often involved structuring arrangements around degrees of independence, with full independence in one's own home, in a satisfying partnership and in paid employment achieved by few. In this respect, facilitating independent living was a normalisation process, enabling people to be as much in 'the community like anybody else… ' (Clive, 29.11.02, non-clinical).

The core concern thus manifested itself both in binary code (dependence v. independence; pathological v. healthy) and as a continuum, with pathologies of dependence at one end and healthy independence at the other. Evidence for the continuum is illustrated in the next section which shows how staff resolve this core concern and the quotations provided demonstrate how participants spoke about 'phased progression' from dependence to independence, 'transition through to the community' and 'return (back up the continuum) to hospital' (dependence). Thus the

resultant theory is about position and/or movement between these two poles through time.

Core category: Facilitating independent living

The core category in this study was about the resolution of pathological dependence. This was achieved through facilitating independent living. Attainment of the highest level of independence for patients was the principal goal for health professionals: ….' (a good outcome).....is independent living, because that is what we aim for. A bad outcome is not achieving independent living'. (Julian, 08.08.02, Forensic Psychiatrist).

Facilitating independent living refers to the basic social process of helping patients become more independent and move to the community, and appears to occur in two principal phases: Phase I, a pre-discharge phase and Phase II, a post-discharge phase. The process is about overcoming pathologies of dependence and independence. For those who are facilitators, independent living appears as a continuum with full pathological dependence at one end, with the patient incarcerated and full healthy independence at the other, with the ex-patient free in the community, and professional help exclusively at his/ her request.

Facilitating independent living is directed at the goal of increasing independence. It can, however, include temporary increase in dependence. Kaliski (1997), for example, suggests that many patients benefit from lifelong attachment to a forensic unit, which allows for many episodes of independent living interspersed with returns to the unit for stabilisation if there is any indication of deterioration, but before the occurrence of any disastrous event triggered by the illness. Transition into the community could be characterised for some patients as a multiple exit/re-entry/re-exit cycle. Each return is treated as an opportunity to examine and modify the previous clinical plan, and enable the patient to resume considerable self-sufficiency whilst perhaps never attaining complete separation/independence from their forensic unit.

Strategies for facilitating independent living

Early stages in the discharge process of a patient with serious mental disorder involve clinical and social efforts directed at enabling disengagement from exacerbating or undesirable behaviours (e.g. dependence on drugs or alcohol) on the one hand,

and engagement with clinical and institutional requirements on the other. This is paradoxical, in that such high dependency on clinicians and services would be construed as pathological in the absence of serious illness, but, given illness, it is people who cannot achieve that dependency who are regarded as having a pathology of dependency (i.e. when they fail, in Mechanic's (1995) terms, to give up their usual roles to take on the 'proper role' of a sick person, namely taking on the task of getting well). If there is recovery from the illness, but failure at this point to give up such dependency, then once again dependency per se becomes pathological.

Facilitating independent living is achieved through paving the way and testing out strategies, whereby the management of the 'risk' of deterioration in the patient which might lead to an undesirable outcome is shifted from clinician to patient as part of the normalisation process. Health independence is achieved when the patient makes all major decisions and assumes the consequences. 'Well in some ways we are a nanny institution but we teach patients to take responsibility…..' (Robert, 21.01.03, Education). Patient competency, however, varies over time '…their ability to make decisions for themselves is variable and variable over time. Independent living is where a person is given autonomy to make their own decisions regardless of whether or not they are competent. This varies' (Jim, 17.02.03, SW).

'Paving the way' involved getting people to prepare for post-discharge independence, for example, teaching the person practical skills such as how to budget or cook. Paving the way begins within high security and become less of a feature after discharge. This preparatory process relies on various educational techniques, inclusive of acquiring skills that may help prepare the patient to gain paid employment and/or to 'have a constructive use of leisure time' (Robert, 21.01.03, Education). On pre-discharge wards, working with currencies and shopping takes place – a kind of 'social education rather than literacy. More liberal approaches to escorted leaves' (William, 03.01.03, CFP). Sometimes this strategy just involves encouragement and pushing the patient a little, 'patients are frightened. Sometimes you have to be cruel to be kind and force the issue' (Mike, 07.02.03, OT).

Other teaching involves getting people to see themselves as subjects and objects in social situations. 'We also do role-play

asking what they would do if someone came up to them in a pub and started calling them names. We teach them coping skills…..' (Sarah, 07.01.03, Nurse Manager). Psychotherapy is considered to facilitate independence because it improves self-understanding 'patients who had self-awareness and understanding of their own vulnerabilities, knowing what they need' (Angela, 08.01.03, Non-Clinical). They need to 'become aware of dangerousness of himself to himself' (Michael, 03.10.02, Psychotherapist). Paving the way also involves engaging and informing families who 'hate not being given information. Give them a diagnosis and you empower them……' (Jim, 17.02.03, SW). The process suggests that the greater the cumulative effect of these strategies, the better the outcome.

The second phase of facilitating independent living involves 'testing out'. Testing out involves a patient being given opportunities within and outside the institution to show to him- or herself and to staff levels of competency with new or re-acquired skills. It involves a tentative switch from pathological dependence to pathological independence by monitoring the effects of exposure to life outside institutional care. A property, therefore, of testing out is its experimental nature. Testing out takes different forms at different stages of the rehabilitation process. Initial tests may include observing a patient cook and clean without prompting from the staff; a next stage test might include escorting the patient to shops outside the hospital. Testing out can be extended when the patient is in another hospital of lower security or in the community. It will be '….probably six months on trial leave before a formal transfer would take place' (Paul, 11.10.02, CFP).

Paving the way and testing out overlap to some extent, and the 'preferred' route to independent community living as a phased progression through ever lower levels of security and active clinical input support might be seen as an indicator of that: 'Medium security is preparation for discharge to the community. There are increasing periods of leaves, escorted and unescorted. They are assessed, targets are met. 'About 70-80% will go through some secure setting as an intermediate stage. About 20-30% will go through all levels of security, i.e. high to medium to low secure/rehab' (Clive, 29.11.02, Non-clinical). These people were said to be 'those with clear mental illness who have responded well to treatment…where it was felt necessary to re-assess risk in

a carefully controlled manner by moving patients to less restrictive settings in a stepwise manner' (Geoff, 28.10.02, CFP).

The process of facilitating independent living continues to assist the patient to relinquish pathological dependence, but also prevent pathological independence, whereby the patient rejects further treatment or support rather than accommodating a reduction of it. Instability in mastery of the underlying core problem (pathologies of (in)dependence) means that re-admission to a higher level of security (back to pathological dependence) can happen soon after the initial transfer to lower security. This can vary by disorder. 'Break down because of change of environment, new team. Could either be people with psychopathic disorder – issues around attachment/ trust/confidentiality or long-term chronic schizophrenics – stress of moving' (Julian, 08.08.02, CFP). It can also vary with the nature of transition. Sometimes patients would have 'to start over with psychologists and prove themselves all over again with a new clinical team' (Angela, 08.01.03, legal representative). Good communication between old and new teams is important to smooth progression along the continuum.

Facilitating independent living: Enhancers and barriers

The facilitating process is affected by 'enhancers' or 'barriers'. Many factors can be either. Enhancers include available support systems or confidence of the clinical team. Barriers include permanent inhibitors which cannot be changed, for example past violence or crime and personal characteristics, and temporary inhibitors which can, like medication compliance or service provision. These are comparable to the fixed dispositional and historical factors and mutable contextual factors described by the MacArthur risk study group (Steadman, Monahan, Applebaum, Grisso, Mulvey, Roth, 1994). While enhancers tend to allow stepwise progression, barriers may prevent, slow or abruptly cut off the process. A barrier appearing after some progress along the continuum and ending independence gained was called a 'terminator'.

Youth was an example of a 'dispositional factor' seen by some as a potential barrier to facilitating independent living, first in securing departure from special hospital. 'I believe the younger remain for longer… [in special hospital]' (Paul, 10.02.03, SW).

Older, not chronically institutionalised patients were considered to pose low risk of repetition of harm, and so be more safely tested out and gain movement towards independence. Over time patients mature and the personality disorder could be outgrown or mental illness burnt out. 'Special hospitals …… allow the personal maturation process.' Researcher: So are older people more likely to go to the community then? Yes' (William, 03.01.03, CFP). The opposite view was, however, also expressed. 'The elderly or infirm, those who are older' or 'people with severe enduring mental illness. I would say a small percentage never reach the community, about 20-30%' (Sam, 10.09.02, CFP).

The barrier to facilitating independent living may lie as much with others as with the patient: 'There is a resistance to take on PDs or people who have proved difficult/ assaultive in the past. They believe that therapy is impotent to do anything about patients with PD. They see the risk as chronic and it is difficult to measure and assess clinical risk….people with PD are anxiety provoking' (Paul, 11.10.02, CFP). This pessimism about outcome, and fear about the potential of the people with personality disorder to disrupt services is not uncommon (Coid & Cordess, 1992). Others, however, point to a substantial evidence base for explanatory pathways into personality disorder and effectiveness of some treatments (Taylor, Newrith & Meux, 2006).

The nature of the legal constraint is another contextual factor which may be construed both as an enhancer and a barrier to independent living. Under the Mental Health Act 1983, in a higher Court, a restriction order may be added to a hospital order, if the judge considers it necessary for the protection of the public. This has the effect of restricting powers of discharge, but also ensures that clinicians continue to offer appropriate treatment, support and supervision. Transitional arrangements within this framework tend to be particularly highly structured. It was perceived, though, that unrestricted patients would move through the system more quickly '…by definition they are less dangerous so I imagine a greater number would go directly to the community than the restricted' (Helen, 11.10.02, Non-Clinical). Dell (1980), however, found that patients under restriction orders and others with criminal convictions were, in fact, the most readily placed.

Enhancers to facilitating independent living

Personal characteristics, such as compliance, trustworthiness, motivation and insight, with ability to form, build and maintain relationships were cited by the participants as factors in the patient which would enhance the process of facilitating independence. Achievement of awareness of anxieties about living in the community and of personal vulnerabilities was also an indicator of such useful insight: 'Realisation that mental disorder is for life. Insight is vital….' (Helen, 11.10.02, Non-Clinical).

Clinical team confidence in the patient and reciprocal patient confidence were seen as the other enhancers: 'Outstanding thing is a good relationship between the patient and just one member of the clinical team. It must be based on mutual trust. So it becomes a conversation between two people, one with the knowledge of psychiatry, the other with knowledge of themselves' (Angela, 08.01.03, Non-Clinical). Responsibility for beginning the discharge process is borne by the team but, as the patient progresses along the continuum of independence, it transfers to the patient.

Strengths in the patient's own support systems provided another layer of enhancers: 'Yes, we do look for family support. Stable structures. Someone to watch over them. Encouragement. This would help us decide on absolute discharge' (Helen, 11.10.02, Non-Clinical). 'Family support seems to be vital. For example, one patient was discharged to a staffed hostel but his parents are still willing to look out for him' (Sam, 10.09.02, CFP). Conversely, having no family or friends was seen as a potential barrier to facilitating independence: 'The patients with no family are the most reluctant to leave' (Sarah, 07.01.03, Nurse Manager).

Barriers to facilitating independent living

The offence leading to the admission to high security hospital, an immutable factor, was perceived as contributing to the route of discharge and speed of progression. 'Some will go out via medium security/ regional security, others will go to supervised hostels. Researcher: What factors determine this? Answer: The index offence' (Sarah, 07.01.03, Nurse Manager). Lack of a clear link between the illness and the index offence, or a perception that the mental disorder which had been present at

the time of the offence was untreatable, were both factors which were regarded as barriers to the process. Relationship to the victim was also seen as important, and probably wisely so (Johnston and Taylor, 2003): 'very unusual for anybody to be returned to family, index offence is often against people [in the family]' (Simon, 19.02.03, CFP). Sometimes a high community or media profile, largely secondary to the offence, was thought to pose a further barrier. Pressure from third parties or victims, public hostility, or political sensitivity would have to be managed as well as the actual safety of the patient. 'There are other issues like DSPD [Dangerous Severe Personality Disorder] and sex offenders – those who respond to treatment – but whether they are safe in the community is a different matter. That group needs close support. So stigmatised' (Susan, 12.12.02, Clinical Psychologist).

Some barriers were considered to lie within the patient. These included reluctance to take medication, lack of empathy or insight, resentment of supervision, inability to cope with money and/or to build and maintain relationships. These barriers were all, however, regarded as mutable, and therefore temporary inhibitors. 'They worry that they cannot cope with life out there and money' (Sam, 10.09.02, CFP). Consequences of long-term institutionalisation were also regarded as remediable for many, although not all: 'Patients are scared of freedom and their potential. They need to acclimatise….." (Susan, 12.12.02, Clinical Psychologist). 'Money is an issue – they don't get paid in an RSU [Regional secure unit]. Daytime activities are another. Integration or not is another….family closeness. Access to the community' (Deborah, 17.02.03, Community Psychiatric Nurse (CPN)). By contrast, co-morbidity, here meaning drug or alcohol abuse co-occurring with the main mental disorder, was commonly construed as a problem for life. It was often thought to play a part in terminating independent living. Problems with alcohol are strongly related to re-conviction and re-admission (Norris, 1984), and patients with such co-morbidity are 'difficult to place' because of not falling within responsibilities of one single agency (Johnstone, Owens, Gold, Crow & Macmillan, 1984).

Women patients were said to encounter more barriers to the process of facilitating independence than were men: 'I think females have more problems with consistency of staff; they are more complex and harder to manage' (Deborah, 17.02.03, CPN).

Also: '…often there has been abuse.. . very little thought about what they do need' (Simon, 19.02.03, CFP).

Another demographic, ethnic group or race was seen as a potential barrier because of a likely mismatch between race of patient and of authority figures: '…There is a cultural difference – managers are white, Tribunals have white people. There is a definite disadvantage to being black' (William, 03.01.03, CFP). This may have similarities with suggestions of such problems in the Criminal Justice System (e.g. Hood, 1992; Fitzgerald, 1993). The NHS generally is not regarded as immune to such problems. Bhui, Stansfeld, Hull, Priebe, Mole, & Feder (2003) found that black people are over-represented amongst in-patients and four times more likely to experience a compulsory admission than white people, although adjusting for diagnosis reduces such difference (Harrison, 2002). African Caribbeans with psychosis are, however, no more likely to be in an English high security hospital than in general psychiatric services (Walsh, Leese, Taylor, Burns, Creed, Higgit, & Murray, 2002).

External factors were sometimes seen as barriers in themselves, including delays in Home Office approval of plans for restricted patients. Further, some placements require identification of new funding, with delays in locating it. Lack of suitable beds was also raised: '….. There may not necessarily be a purpose in sending them to medium security but it is to do with bed availability' (William, 03.01.03, CFP). A further set of barriers were considered to lie in staff training. Decisions about transferring or discharging patients are influenced by attitudes and philosophies among receiving clinicians, as well as by their knowledge of the patients (Peay, 1989). 'Many staff are not trained forensically' (Sarah, 07.01.03, Nurse Manager). For other staff, an "unlearning" of previous experience would be needed (Rawlings, 2001). 'I think the route you come in can seriously affect your thinking. Some staff come onto the admission ward having worked in the community. People don't always apply security. I think there is a division between mental health and forensic' (Mike, 07.02.03, OT). Again, the theme came through that patients with personality disorder might experience special barriers: 'Inexperience with the community team. They have never been trained how to deal with people with personality disorder. They will be successful with MI. Community psychiatric services do not want to know people with PD so the

team does not get experience. Community Psychiatric Nurses need more training' (Jim, 17.02.03, SW).

Outcomes

A 'good outcome' of the discharge process was having 'successful accommodation, employment, a lack of drug use, limited alcohol intake, maximised his/her potential, secure relationships of his/her choice, a constructive and contented life, the ability to deal with problems, and being in the most independent placement possible, compliant and not institutionalised'. 'Return to safe responsible 'independent' living that they are happy with' (Helen, 11.10.02, Non-Clinical). Additionally, there must be a lack of re-offending and re-hospitalisation and being free of, or at least untroubled by, symptoms.

'Bad outcome' was characterised by lifelong pathological dependence and institutionalisation, with no self-sufficiency for the patient, long re-admissions to hospital, re-offending, suicide, relapse, or being stuck in an inappropriate placement - 'Staying with no prospect of moving on or moving on to MSU with no rationale for moving there' (William, 03.01.03, CFP). A bad outcome also referred to premature discharge, a form of pathological independence. There was also recognition of high rates of physical ill health 'There is high morbidity due to smoking and lack of exercise. Suicide rate in schizophrenics is about 11%' (Tom, 18.10.02, CFP)

Such good and bad outcomes constitute extreme poles; for most patients, it was more a case of 'As good as it gets….' where this would refer to the very best progress that a patient could make. 'To become as independent as possible recognising that some won't make it to the end' (Tom, 18.10.02, CFP). In this context, 'the end' or the real aim of discharge could be taken to mean healthy dependence. To this end there was recognition of the value of teaching patients to be as dependent as they feel they need be to meet real needs. The dependence only becomes pathological if independence is the healthy, appropriate adaptation and vice versa.

A patient may be appear to be living independently, not offend, not be re-admitted, and comply with all requirements but have no quality of life, no job, self-esteem or relationship. 'It doesn't matter what the job is but they need an occupation – it

could be a porter, whatever, but it needs boring regularity coupled with friends. If there was family support on top, that would be marvellous' (Michael, 03.10.02, Psychotherapist). Occasional relapses would be acceptable: 'Living in the community; 'blips' get noticed perhaps with 'blipping' admissions; low level offending (not violence)' (Simon, 19.02.03, CFP).

Summary

Information derived from interviews about discharge of patients from high security hospitals, undertaken with a mix of clinical and non-clinical staff involved in decisions to discharge, revealed a core concern about pathologies of dependence and independence. This was accompanied by recognition that a measure of dependence could be healthy if freely chosen; examples of pathologies of independence include enforced detachment from services or total rejection of attachment. The emergent theory was of a process of facilitating healthy independent living, with two principal phases, which overlap. These phases are 'paving the way', mainly occurring in the pre-discharge period, and 'testing out' occurring more in the post discharge phase.

Facilitating independent living is an active process by clinicians and other professionals creating movement from full pathological dependence at one end of a continuum, - here, compulsorily detention in hospital - towards healthy independence at the other end – here, when the patient becomes a person who is able to live safely in circumstances of his or her choosing, whether alone or with a partner, family or friends, and with or without professional help. In this model, progress and deterioration are movements up and down a dependence-independence continuum, personal or social network strengths are enhancers of progress towards independence and adverse events, such as relapse of illness or re-offending, barriers to independence, in themselves and in the nature of the responses to them – perhaps return to hospital.

Discussion

The theory generated provides a positive and fresh framework for understanding and measuring outcome on leaving a high security hospital, which fits better with a philosophy of clinical practice and rehabilitation than old methods of focussing almost exclusively on re-offending, or, from time to time, on other

negative events. The majority of people leaving high security hospitals are not now and never have been convicted of a further offence; e.g. in the UK, Buchanan (1998), Jamieson and Taylor (2004), Tennent and Way (1984) and Tong and Mackay (1959); and, in the USA, Steadman and Keveles (1972) and Steadman and Cocozza (1974). If used alone and without context, this is an unsatisfactory marker of outcome because the offences these patients commit tend to have a low base rate, some patients may be violent but escape involvement with the criminal justice system, and both the definition of offences and attitudes to them, including the likelihood of prosecution vary geographically and over time. A model which is less susceptible to social and cultural vicissitudes and which more explicitly puts gains for the patient as well as others at the centre of the rehabilitation process is likely to enhance co-operation between staff and patients and, in turn, the chance of good outcomes.

This perspective fits well with the ethical code of most people providing services for such patients, and may also fit better with community safety than a risk focussed approach. Munro and Rumgay (2000), for example, analysed a consecutive series of independent inquiries after homicide by people who had been in contact with UK mental health services, published 1988-1997, and found that even with the advantage of hindsight, only one quarter of the inquiry teams had judged the homicide as having been predictable, but in two-thirds it was considered that it may have been preventable with treatment. In other words, focus on the patients' health and social needs rather than their offending would probably have been more effective in prevention of these tragedies.

Our theory of facilitating independent living also has important implications for the broad social processes of de-institutionalisation and the move towards community care, designed to help patients achieve independent living. One of the guiding principles for the treatment of mentally disordered offenders in the UK Department of Health & Home Office's (1992) Review of Health and Social Services for Mentally Disordered Offenders was that they should be cared for "as far as possible in the community, rather than in institutional settings"; "under conditions of security no greater than is justified by the degree of danger they present to themselves or others" and "in such a way as to maximise rehabilitation and their chances of sustaining an

independent life". Indeed, the whole concept of 'community care' is about providing care for mentally disordered people outside hospital in community residential settings, allowing them the freedom to make their own decisions. The process aims to ensure that some of the protective functions of the institution are fully provided in the community and the negative aspects of institutional care are not perpetuated (World Health Organisation, 2001). Thus, de-institutionalisation is associated with "de-hospitalisation" but not synonymous with it. A package of resources, including health workers and rehabilitation services, general hospital psychiatric beds, other specialist accommodation and home care, crisis support, protected housing, and sheltered employment allows service users more choice in selecting the optimal cluster of resources for their needs. Although terms such as 'protected' and 'sheltered', however, carry some connotations of dependency, elements of choice on the part of the service user and openly negotiated agreement between clinician and user on the choice of service use implies a substantial measure of healthy independence.

The core problem that this theory articulates is that a complex dynamic exists between pathological dependence and pathological independence. We all are dependent on such things as food, money and relationships in our lives, to various extents, but the level of dependence and independence should interact positively with each other to allow an individual to develop or maximise his/her potential and to have some control over the balance of dependence/ independence. It is a fundamental characteristic of a social being that he or she is not wholly self-sufficient, practically or emotionally. As human beings, we depend on relationships with others to survive, and interaction with others is generally reciprocal.

There is, nevertheless, a general pattern among healthy social animals that they start life as highly dependent on one or both parents or caregivers, and progress towards increasing capacity for independence, including autonomy in choice and actions. Some kind of disruption to this process may be referred to as a pathology of dependence. For people with developmental disorders, such as learning disability or personality disorder, such progression may be slowed or arrested. Among mechanisms for understanding the latter, is disorder of attachment (Bowlby, 1969; Barber M., Short J., Clarke-Moore J., Lougher M., Huckle

P., & Amos T., 2006).

Direction and stability of pathologies of dependence may be affected, such that an individual might be rendered over-dependent at one extreme, autistically separate and without reciprocity at the other, or swinging between the two. Illnesses, disorders which constitute a break in health, may also affect dependence. The nature of care and treatment for such disorders may compound any pathological dependence directly related to the disorder. Where disorder is profound and chronic, and long-term care and treatment has been provided in an institution, this is particularly likely.

The aim that a child should grow up to become confidently independent is synonymous with the aim that he should grow up to be mentally healthy (Bowlby, 1956). There are parallels in the aims of clinicians, and their sometimes parent-like roles in easing a patient along towards independence. While not expressed by any of the interviewees, a difficulty here is the risk of reinforcing a sort of pathological dependency, colluding with a form of infantilization of the patient. Most patients are well over 30 years old by the time of consideration of discharge from high security. Many of them experienced pathological attachments within their family; most would have felt or been pathologically dependent, whether or not that dependence was met, when their mental disorder left them less able to survive independently in the community. Both schizophrenia, which most commonly has its onset late in adolescence, and personality disorder, which has generally affected the individual for the whole of his or her life, interfere with the normal process of gaining independence from parents/parental surrogates. Work with families, with the consent of the patient, is likely to be important.

Forms of dependence can be both natural, as in a mother-child relationship, and pathological from a societal point of view, as in institutionalisation. A further distinction exists between forced dependence, as in incarceration, and free-choice dependence, when deprivation of a particular object, person, or substance or place would cause distress. This can be seen in patients who are distressed when discharge is considered. One way of looking at violence born out of paranoia is that it is a disruption of a former pathological dependence created by a belief system about a perceived persecutor. Treated patients who have been freed from such pathology may experience emptiness

without the beliefs and mourn their loss.

A flawed notion of community at the heart of the process of de-institutionalisation in some respects contributes to the pathology of independence. Communities are complex tapestries of social and political forces, not always welcoming to those who are committed to its care. A more critical awareness of what community actually means in community care is needed.

Generalizability

This theory is substantive because the focus has been on a specific area of inquiry that concerns inter-disciplinary practice. The aim of facilitating independence for people who have been detained in high security hospitals appears to have much in common with the overarching aim for psychiatric patients or other people in institutional care, in which case, the implications are profound for the theory and its generalizability. In order to develop or refine the substantive theory further, resident patient views should be obtained. In order to build formal theory pertaining to the conceptual area of pathology of dependence, the phenomenon should be examined under several types of situations, such as people with mental illness living in the community and within hospital, both before and after treatment. This would have the aim of exploring further how the discharge process affects the pathology of dependence, as entry into the patient role (or sick role) is often a last resort, following extensive delays and repeated attempts at self-care (Mechanic, 1995). Further work could examine Bowlby's (1956) distinction between actual dependence and feeling dependent. It could be that for patients with little experience of survival in the community, the feeling of dependence is hard to overcome and thus a patient may appear to an outsider to be living independently and to be in a free-choice state, but in reality have feel very dependent.

Since this theory was developed, a paper has been published by Draine, Wolff, Jacoby, Hartwell, & Duclos, 2005, who developed a model of prisoner re-entry into the community through interdisciplinary team effort and refined through a focus group process that included advocates, community members and other informants from mental health and criminal justice systems in five states. It illustrates dynamics related to both individuals with mental illness leaving prison and their interaction with the community setting. It also has distinct

parallels with the theory presented in this paper in terms of Enhancers and Barriers as the authors model how resources and needs at both community and individual levels can interact to support or hinder the community integration of individuals leaving prison.

Limitations

The principal researcher (LJ) who conducted all the interviews and the analyses is not a clinician, and had few preconceived ideas about discharge and outcome for high security hospital patients, however, she did regularly attend clinical seminars, and the principal supervisor (and one of the co-authors) is a clinician of long experience at all levels of secure service provision and management. Every attempt was made to approach this material with an open mind, and to reintroduce prior knowledge and research evidence as a final stage of the analytic process, but bias cannot be ruled out.

The theory that was developed is not necessarily the only one that might plausibly have been derived from the data. Sometimes it is possible to account for behaviour by more than one concept. However, the theory derived in this study was the interpretation of the data and all decision-making processes have been made explicit by giving examples of direct quotations. Every attempt was made to ensure that theoretical saturation had been achieved but new information might have arisen had the interviews continued and this is true of any grounded theory study. A grounded theory is never right or wrong but is always modifiable in the light of new information. For example, this study only examined outcome from the perspective of those making discharge decisions. Addition of a service user perspective might result in key modifications.

Conclusions

It was possible, by adopting a grounded theory approach, to develop a substantive theory of facilitating independent living that explains the main concerns with discharge from special hospital, according to mental health staff. After 20 interviews, the theory was saturated. The theory developed was that discharge for special hospital patients is a process of facilitating independent living. Independent living is portrayed as a dependence-independence continuum. The process is facilitated through strategies of 'paving the way' and 'testing out', to each of

which both patients and others, especially professional staff, contribute. The process is affected by 'influencing factors', which may be 'enhancers' or 'barriers', and these in turn may be in the patient or in their external environment.

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