Citation: Savory. A. (2017). *Risk management of those with poor mental health*. [ONLINE] Available at: http://www.SavoryScriptsandScribes.com. [Accessed: (date article was accessed)].

Risk management of those with poor mental health

Abstract:

There are good and 'royal' inroads being achieved to reverse the stigmatization of the acceptable face of mental illness, that is the middle-class depressive. The article asks for the same courtesy to be extended to those in poverty who are situated in the perceived dangerous and risky place of social housing. They only become visible when they are in a mental health crisis due to lack of support, engendering communal fear. The discourse will utilize Beck's definition of risk in relation to the processes and systems in which hazards are managed and how risk emerges through modernisation itself (Beck, 1992). Foucault in his 1989 treatise on madness and civilisation explores what he calls 'decarceration' (Foucault, 1989). In England and Wales, this means the de-instutionalisation of many people who were once confined in mental hospitals, due to their lack of value to society (Hamlin & Oakes, 2008). Legislation attempts to give structure to how these people would be able to live their lives within a community (for example Care in the Community Act; 1990). Albeit Anti-Social Behaviour (ASB) legislation has worked against this structure, providing a way to criminalise behaviour once seen as a nuisance (Squires, 2008), it can also be seen as 'lawful discrimination' (Pilgrim, 2017; p. 201). However, the risk that the public perceive has been fed by modern media, so that mental illness and dangerousness are strongly associated (Pilgrim, 2017). This is not helped by Thomas Szaz's work on anti-psychiatry and whether mental illness really exists objectively or if it is a myth that causes more harm (Szasz, 1974; 2010). This is a risk for the person as it robs them of possible support if poor mental health is not seen in the same way as a physical illness. The only other route is through criminalisation. This has become apparent in England and Wales, as has been noted by Lord Bradley in his report and follow up of mental illness and prisons (Bradley, 2009; Durcan, Saunders, Gadsby, & Hazard, 2014). The article concludes that the risk the public perceive from those experiencing poor mental health in their community provides tensions for authorities. This is a 'perceived' risk, unlike the 'real' risk to the individual of criminalisation instead of support for the health needs. Using data from the authors own research (Savory, 2016), it will conclude that society needs to address the issue of how to support people and not criminalise them when their behaviour does not conform but is the result of poor mental health.

Risk management of those with poor mental health

Introduction

Conventionally, the psychiatric study of mental health focuses on the nature of the abnormality, the causation of it and the methods developed to ameliorate the behaviour (Carson & Butcher, 1992). Social medicine emerges in the eighteenth century as a programme of political intervention to prevent ill health (Rosen, 1979). In recent decades, the focus has shifted further towards this political stance (Squires, 2017) as advocates of community safety agree that public protection must be a priority (Bean, 2001). With this in mind, the state and medicine work in tandem to achieve the goal, even though they are seen as opposing influences (Busfield, 1996). This is done as those experiencing poor mental health are viewed as a risk. Extant literature acknowledges this, suggesting that the media promotes the fear by inferring that the 'insane' are a lurking threat to society (Bartlett & Sandland, 2014).

The great confinement of the seventeenth century in new institutions, imprisoning those with mental health, can be seen as a 'Cohenesk' moral panic (Cohen, 2002) about the poor and idle. This ends with the 'decarceration' in the twentieth century of the same group of people (Foucault, 1989). What follows is 'care in the community' and the influence the public has on the individual (Bean, 2001). As the transfer to the community take place, sociological theory and government policy becomes influential on the meaning of mental illness. Most recently the current interest of politicians is one of 'well-being', focusing on what makes people happy and trying to achieve this (Pilgrim, 2017). The impact is on what it is to be mentally healthy, linking personal distress and social organisation (Banton, Clifford, Frosh, Lousada, & Rosenthall, 1985).

Recently, there have been many inroads into what mental illness is and how it should be discussed and not feared. Ruby Wax, among other celebrities, talks laudably about her experience with depression in 'Time to Change'. This is one of the many websites springing up around the topic[1] that pledges to end the stigma of mental health. Stephen Fry, on the same website, discusses his bipolar diagnosis and how important it is to fight the prejudice that exists over mental illness, saying;

[1] https://www.time-to-change.org.uk/news-media/celebrity-supporters/ruby-wax

> *"Once the understanding is there, we can all stand up and not be ashamed of ourselves, then it makes the rest of the population realise that we are just like them but with something extra."*[2]

Most recently Prince Harry has spoken in the media about counselling after his mother's death[3]. Sir Simon Wessely, the president of the Royal College of Psychiatrists, said this 25-minute interview by the prince has done more for mental health awareness than he had in a 25-year career[4]. In 2016, Harry with his brother and sister-in-law, the Duke and Duchess of Cambridge, launched 'Heads Together,' along with eight charity partners, to encourage people to talk about their mental health challenges[5]. MIND organisation has over 140 local offices and support over 390,000 people across England and Wales. Their services include supported housing, crisis helplines, drop-in centres, employment and training schemes, counselling and befriending[6]. These services exist, along with the state run mental health teams, all with the aim of supporting those who experience poor mental health or who have a 'variable mental capacity' (Savory, 2016). The celebrities are accomplishing more than the psychiatrists in this area. It can only do good.

However, it can be suggested that all this 'good' talks to the middle-class mother with depression, the stressed-out office worker being given one too many tasks to do, or the celebrity obsessed young teenager in the bedroom of their family home. Whilst not reducing the impact on this section of society, the problem is that it does not talk to the lone unemployed and poor individual with schizophrenia who has been discharged from the hospital with his medication and a small social housing flat, with no family support network. This support would help him take his medication even when he thinks he does not have to because it makes him feel better without it. The ensuing and sometimes violent behaviour then causes the community to fear him and he has nowhere to go once he is within his mental crisis, other than back to hospital or prison. It doesn't talk to the young unemployed woman coming out of care who has obsessive compulsive disorder (OCD) living in a second-floor social housing flat and whose neighbours are being constantly irritated by the banging of doors caused by her mental condition. The young woman on a short hold tenancy

[2] https://www.time-to-change.org.uk/news-media/celebrity-supporters/stephen-fry
[3] http://www.telegraph.co.uk/news/2017/04/16/prince-harry-sought-counselling-death-mother-led-two-years-total/
[4] https://www.theguardian.com/society/2017/apr/17/prince-harry-grief-revelations-praise-mental-health-experts?CMP=twt_gu
[5] https://www.headstogether.org.uk/about-heads-together/
[6] http://www.mind.org.uk/about-us/

then has the risk of becoming homeless, as her tenancy is not renewed because of her anti-social behaviour (ASB).

This article will be using Becks concept of risk to explore how the hazard of an illness, with little or no cure, that cannot be traditionally managed as a physical illness, is negatively viewed. The exploration will be done by using recent research (Savory, 2016) along with extant literature. The 2016 research focuses on the social housing tenant as this is where those with poor mental health and no support network usually reside (Manzi, 2010). Literature defines this as a 'residual approach' to social housing (Mullins & Murie, 2006; Pearce & Vine, 2014). These are individuals unable to join the ranks of private ownership as they cannot provide for themselves, cannot rely on family care, or further their interests in the market economy (Titmus, 1974). However, the needs-based housing management has been criticised for allowing dependency and a culture of entitlement by those not attempting to better themselves (Reeves, 2014). A recent piece of research conducted by Shelter regarding mental health and housing indicates that the insecurity of tenancies can contribute to poor mental health[7]. Therefore, those with poor mental health live in a social housing community with the regulations that surpass those in private dwellings. This contributes to the stress that can then lead to further deterioration of their health and to behaviour that would be perceived as Anti-Social; the result being the potential loss of their home.

The article starts with how mental illness is socially constructed. With the social construction comes the fluid concept of risk. It can be suggested that it is a 'perceived' risk to the community from the individual with poor mental health and a 'real' risk of criminalisation of the individual who is more in need of support (Savory, 2016). The community, and what it means to be part of the community, is discussed, as those who do not conform with this ideal are also at risk of being socially excluded (Young, 1999, Pilgrim, 2017). Towards the end of the article, present resolutions to the 'risk' are discussed. This will include support and law enforcement, dependent on the individual's behaviour and intent, and the consequences of the action taken to resolve the risk to the community.

The 'Myth' of Mental Illness

Szasz suggests if mental illness is defined as a medical disease it can only mean it is something people 'have.' However, behaviour is what people 'do.' He continues by arguing that as diseases are defined as malfunctions of the human body, how can mental illness, even if the exhibited behaviour is

[7] http://england.shelter.org.uk/__data/assets/pdf_file/0005/1364063/Full_report.pdf

unreasonable and irrational, be defined in the same way. Ergo, objective mental illness could be seen as a myth (Szasz, 1974; 2010, 1997). He warns of the danger of absolving individuals of the responsibility for the actions to blame their illness and the harm this does. An illustration of Szasz's anti-psychiatry mode of thought can be found in the recent research (Savory, 2016). When mental illness is combined with an addiction to drink and/or drugs it is termed as 'dual diagnoses'. There is a preference to see the criminal behaviour of substance misuse and ignore any mental illness. The individual is held to account for their behaviour and not supported for his/her ailment, in the same way as a physical illness would be managed.

However, there is a lot of literature that drowns out Szasz's viewpoint. It suggests that there is such a concept as mental illness, which can be defined on a sliding scale of severity along with how society reacts to it; a social construction (Foucault, 1989). While many theorists, researchers and writers have adopted social constructionist viewpoints in relation to medical knowledge, it is Foucault's work which is one of the best known and which has contributed influentially in developing this theoretical viewpoint. Foucault's work is mostly concerned with the shifting conceptions of what madness means to society, leading to the development of a discrete set of knowledges which studies mental states according to the classificatory system (Foucault, 1989). This is apparent in today's use of the International Classification of Diseases; ICD-10 (WHO, 2016), ICD-11 to be released in 2018 (WHO, 2017). Foucault discusses the 'medical gaze' that is held by, amongst others, doctors who can diagnose an individual in order to treat them (Foucault, 1993). This gives the owner of the gaze power over that individual as they seek a cure to ensure they return to societal norms.

Sedgewick (1982) rejects the idea of a dualist approach of mental and physical illness, in favour of a unitary concept of illness (Cresswell & Spandler, 2009). All illnesses and sufferers to be dealt with in the same way. However, the management of mental health in the last century was far from this value-free Sedgwickian ideal, as can be highlighted by the emergence of the ICD mid-century, published by the World Health Organisation (WHO). Although in the twenty first century, in policy terms, it is not as pessimistic as the literature suggests. Cresswell and Spandler point out, there are plenty of supportive programs now offered to those experiencing poor mental health that do not rely on clinical diagnosis. This is illustrated in recent research by way of day centres that provide somewhere those with poor mental health can go and receive respite with professionals on hand to help (Savory, 2016). Albeit recently, due to lack of state resources, day centres are closing as alternatives are found to an 'outdated concept' (Pitt, 2010).

With the literature trying to define what it is to be mentally ill, it means the condition does exist in the work and minds of those governing social policy, the practitioners of mental health and those researching the issue. How it exists can be answered through the social and medical impact of others onto a person. Why it exists can be explained as a desire for all to be 'normal', so we can all exist harmoniously with one another in society. A medical diagnosis of mental illness as a biological disorder, to be treated chemically, can only provide a limited explanation of whether it exists or not. As Szasz discussed, poor mental health is also to do with behaviour.

Normal to accept support, abnormal not to

According to Foucault, within society normalisation occurs with the creation of an idealised norm of behaviour (Foucault, 1977). For this influential philosopher, the norm is established through institutions and structures of discipline. Although he was writing 40 years ago, it can be suggested through recent research that this is still the case. A housing institution can be considered a structure of discipline ensuring tenants conform to their tenancies. The housing professional has few options but a disciplinary one when a tenant is exhibiting behaviour that is perceived, by the community, to be a risk, although not perceived as in need of treatment or support by state mental health services. The main option in this situation is to threaten eviction/evict and/or punishment (Savory, 2016). Tenants also see this as a punishment to revert to societal and housing norms of behaving;

> *"… the council, they helped me in some respects, but they didn't in others. I mean there was no need to take me back to court again for the same thing just because they thought I wasn't punished enough. That's what I think. But I'm sorting myself out now." A social housing tenant (Savory; 2016, p133)*

Part of being 'normal' is being proficient within our social role with all actions readily lucid to others and not perceived to be a risk. When this breaks down, it can be understood as poor mental health, therefore perceiving mental illness sociologically and as incomplete socialisation (Pilgrim & Rogers, 1999). This is not value free and being normal in one time and culture may be enough to describe a person as ill in another time and culture. As values change, the notion of what is normal also changes. Mental illness exists in the form of social conformity rather than anything in isolation to that (Branden, 2001). This existence is then perpetuated by society who can judge a person so diagnosed. The concept of labelling (see Becker's seminal work '*Outsiders*' 1963) situates behaviour due to poor

mental health within social explanations. As this happens so the explanations become vague and fuzzy, leading the exploration of this subject away from the objective science of an easy diagnosis through the ICD-10 by medical doctors. It can be argued that this is because the governance and policing of the exhibited behaviour has been overtaken by those who have not been specifically trained in the practice; for example, housing officers (Savory, 2016). Some would aver that the aim of these people is to control what is seen as a moral failure (Foucault, 1989). Foucault also suggests that the way of managing those who are behaving in an abnormal manner is akin to trying to achieve '*docile bodies*' (Foucault, 1977). Foucault's term '*docile body*' can be understood to be created by 'mechanisms and technologies of dominance and coercion' (*ibid,* pps. 135-169). Individuals are under constant scrutiny in ways that may appear to be invisible to them because they have become such a pervasive part of society. Being continuously monitored creates a passive acceptance. This passivity makes them '*docile bodies'*.

A society who must follow rules is appropriate, as not to do so would result in anarchy. Policy and practice are littered with this method of normalisation for the laudable aim. However, normality is situationally and/or culturally relative. Who defines normality is not usually those who are abnormal. It is another example of social construction, when the construction of normal is who decides on normality. That is a risk to those who are abnormal rather than anyone else. As illustrated, to be thought of as abnormal or deviant in some way is to be 'shun[ned] for being a looney' (Savory, 2016; p.113).

Stigma and labelling playing their part in normality

It can be proposed that those who witness the individual's 'deviant' behaviour doubt the reality of it being a treatable illness, deserving of support. Rather they fear the behaviour is bad or dangerous deserving of punishment or at the very least controlled by policing agencies. The person is then stigmatised as, what Goffman would suggest, a 'spoiled identity', which is the disqualification of all that is acceptable within a normal society (Goffman, 1986). This brings their whole identity into question. Stigma arises when the social identity of a person falls short of what is socially defined to be the ideal identity (Crawford & Brown, 2002). Within the Time to Change research, "*87% of respondents in 2014 said that people with mental illness experience stigma and discrimination*" (WHO, 2016; p.42). More research indicates that stigma can actively stop some people from seeking help (for example Xu et al., 2016).

Labelling can be and is done by members of the public with an academic emphasis on the role of societal reaction in the stabilisation of a mental

disorder (Scheff, 1966). Many theorists prefer the term 'interactionist approach' to labelling, as it considers all those associated with the development of the deviant behaviour in a collective action (Becker, 1963 (1997)). The public perception of those so labelled as mentally ill are stereotypically portrayed as unpredictable, dangerous and unable to care for themselves. If this is how society views a person then the person's condition can worsen due to the way they are treated (Thoits, 1999). It can be surmised for the purposes of this piece of work that whether mental deviance is caused by society or not, public opinion does have a part to play.

There have been many theorists that have rooted mental illness within society, suggesting that the symptoms are variations of residual social rules; whatever behaviour is left when other behaviour has been defined (Scheff, 1996). Also, that people who are labelled as deviant and are treated as deviant, become deviant (Thoits, 1999). It can be posited that society has no direct influence at all on causing mental illness and that the societal perceptions come about as a direct result of the behaviour and not the illness. Ergo, the mental illness is not feared but the behaviour that is exhibited. Any label could prolong the issue but is rarely the full cause (Gove, 1975). If society is to blame for labelling the insane then it would be expected that the images lay people have would conform to the images of diagnosis. Yet research has shown that this is not the case. Indeed, lay perceptions to mental illness have been demonstrated to only marginally relate to the images associated with medical diagnosis (Pilgrim & Rogers, 1999; Pilgrim, 2017). The public can now become experts, thanks to the information gleaned from the mass media. However, not expert enough to achieve the right understanding, but just enough to be fearful of the abnormal. Disciplinary structures and organisations justify the criminalisation of those with poor mental health if the 'dangerous' behaviour is not part of the ICD-10 symptom list. There are few alternatives open to those managing individuals who display behaviour the community mistakenly insist is a risk or abnormal.

The voluntary status of the available services and support is an issue that can alter the way a person can be diagnosed. What is apparent is that once a person has accepted the support; a proper judgement of their health can take place. Albeit, this can lead to them being labelled whilst society still retains the negative view of mental illness (Bartlett & Sandland, 2014). This is illustrated in recent research (Savory, 2016);

> *"Some people would sympathise and make allowances and other people would shun you for being a looney... I don't think it would*

> *advantage me anything if they [knew]". A social housing tenant (Savory; 2016, p.113).*

A person's internal evaluation and how they judge themselves, considering what they perceive to be cultural and societal norms increases the stigma (Overton & Medina, 2008). Their self-esteem is reduced by the idea that they do not live up to the expectations that others in their environment impose on them (Blankertz, 2001). The expectations would include taking up any support offered. A societal definition or label conveys upon an individual a stereotypical image upon which the person will then act out as that image dictates (Becker, 1963 (1997)). Acting as a deviant to the norm will achieve a negative label and the risk of being excluded. In this instance, one who is mentally ill who wishes not to be excluded, needs to take up legitimate offers of help so they can return to the 'norm' (Scheff, 1966, Pilgrim, 2017) and the hope that they would not receive a negative or deviant label. They will fit into an acceptable 'norm' of an individual taking responsibility for their health and well-being. Society does not mind if a person is ill, if they do something to make themselves well again. Research indicates that if they take up that label they are more likely to have a positive view of the support on offer (Xu et al., 2016). Within the recent research, one of the interviewees illustrates this notion as he took on the mantle of being mentally ill and was '*active in [his] own recovery*' (Savory, 2016; p. 117).

The fear of being labelled and stigmatised and therefore disqualified from society can hinder the desire to seek voluntary support as the concept of mental illness and danger appears to be interchangeable. State run services and the police manage people exhibiting dangerous abnormal behaviour. However, via the legislation, there is strict criteria that, unless the person is a danger to themselves or another, they will not impose support upon them (Savory, 2016). That is within a public space where police have the authority to detain them (Mental Health Act 1983 (2007) s136). In private premises, a warrant needs to be issued if a person appears to be experiencing mental illness and has been neglected (MHA 1983 (2007) s135). This is the only time support can be forced upon an individual for assessment purposes. Once the assessment is complete, voluntary inclusion by the person is required for further support to be given. By this time, the person has entered a punitive system that encourages the community to fear the risk that they may pose. After all, why punish someone who is not dangerous?

The Concept of Dangerousness and perception of Risk

Conditions such as Schizophrenia, can be diagnosed within the ICD-10. However, it is coupled with violent crime leading the public to perceive the offender as evil and sane; in need of punishment rather than mentally disordered and in need of treatment. Peter Sutcliffe, the Yorkshire Ripper is an illustration of this public attitude (Pilgrim & Rogers, 1999). He claimed mental illness but was judged to be sane under the McNaghten Rules that he knew what he was doing was wrong at the time he was doing it and it was due to a defect and disease of the mind[8]. The risk and danger posed by the violent, and possibly mentally ill offender is more feared than the Anorexic individual, intent on harming themselves only. The public being made aware of the dangerous mental health conditions and crime strengthens their perceived link between violence and mental disorder in their psyche (Philo et al., 1996; Varshney, Mahapatra, Krishnan, Gupta, & Deb, 2016). However, the risk of a psychiatric patient harming others is small with the male gender and substance abuse being more reliable predictors of violence (Pilgrim & Rogers, 1996).

The non-voluntary individual is only offered support once the criteria is fulfilled. The Mental Health Act 1983 (amended in 2007) is littered with words such as 'danger' and 'hazard'. This situates mental health as a risk to be managed for the sake of others rather than for the individual experiencing the breakdown of mental health. Legislation, policy and practice gives the impression that those whose mental health is fragile can be considered dangerous and violent. Within this 'concept of dangerousness', what remains for the individual with poor mental health is the stigma of being violent and someone to be feared (Varshney et al., 2016).

The concept of dangerousness remains a big concern for the public with no real change in this view over the years (Savory, 2016). In a recent report by the Department of Health, respondents were less likely to agree that '*people with mental illness are far less of a danger than most people suppose*' this agreement increased from 57% in 2008 to 64% in 2014 (time-to-change, 2015). However, the term dangerous is more of an ascribed rather than objective quality (Walker, 1978) that is difficult to measure and predict. This means it lacks certainty to reassure the public that any kind of treatment will reduce the characteristic in a person.

Deviant behaviour is how the 'norm' is established and whose interests are served by labelling some behaviour as deviant. By reconstituting ideas of

[8] M'Naghten Rules (1843) 4 St.Tr.(N.S.) 847.

what is normal by making them more tolerant of diversity is a way to reverse this deviance (Gomm, 1996). The by-product would be a change in the way the public perceives those who are not deemed to be normal. The normalisation of previously abhorrent behaviour cannot be done for all deviancies, for example rape and murder, but there needs to be an undercurrent of tolerance and education to take away the public stigma of mental illness (Overton & Medina, 2008). Because, whilst policy makers continue using words like 'risk' and 'hazard' and the medicalisation is of abnormality and 'madness' (Scott, 2014), it will be difficult for individuals to overcome the negativity of the label.

The assumption is made here that mental illness exists even if it is within a social construct, which both the individual and others take part in creating. As discussed, there is a concept of dangerousness that is part of the condition that is a perceived risk to society. Ulrich Beck places his concept of risk within a modern society (Beck, 1992, 1999). In modern society, there are modern problems which include the decarceration of the asylums (Foucault, 1989). Risk society is the way contemporary society organises their response to the risk. According to the German sociologist Ulrich Beck a risk society is "*a systematic way of dealing with hazards and insecurities induced and introduced by modernisation itself*" (Beck 1992; p. 21). Whilst the British sociologist Anthony Giddens, defines it as "*a society increasingly preoccupied with the future [and with safety and security], which generates the notion of risk*," (Giddens & Pierson, 1998; p. 209). Both definitions create a view of a society that is looking at what the dangers of a situation is to them presently and in the future. This is guided by the way the modern world has informed them. It can be suggested that this is one of fear of the mentally ill, through the moral panic engendered by the mass media (Pilgrim, 2017). Only the sensational items are newsworthy (Jewkes, 2015). The mentally ill are among the groups of people who are 'lesser mortals,' especially vulnerable and susceptible to media effects of demonization (*ibid*; p.287). In the public's perception, mental illness and violence remain inextricably intertwined, and much of the stigma associated with mental illness is due to a tendency to conflate mental illness with the concept of dangerousness. This perception is further augmented by the media which sensationalises violent crimes committed by persons with mental illness, in particular mass shootings, and focuses on mental illness in such reports, ignoring the fact that most of the violence in society is caused by people without mental illness (Varshney et al., 2016).

The danger society creates with this is to throw the baby out with the bath water and demonise the many for the faults of the few. It is accepted that

some mental illnesses can result in violence, but this is the exception rather than the rule. Therefore, if there is a risk of violence within a community and the aim of the state policy is to reduce this violence, any inroads to controlling and punishing those who are mentally ill through legislation is an odd method that will not achieve its objective (Bartlett & Sandland, 2014). An explanation for this way of managing sections of a community is to assuage the public fear of the perceived risk to themselves.

With the advent of the risk society, Beck suggests that a community is more likely to build solidarity around fear and anxiety of risk rather than need (Beck, 1992). Risk also impacts on how trust is formed among people and abstract systems. Giddens postulates that trust is built based on a 'leap into faith' that involves ignorance, or lack of information (Giddens, 1991). However, with discourses now not being a preserve of the expert's, 'trust' can be shaken with mistaken knowledge feeding the perceived risk, a situation illustrated by the concept of Moral Panics (Cohen, 2002). What shakes trust is the lack of community engagement, as empirically illustrated by Putnam (Putnam, 2000). It has been argued that the bonds of trust between neighbours and citizens have been undermined by the state that has encouraged the '*surveillance society*' (Jordan, 2010; p.19), which promotes constant monitoring, leading to an ethos of distrust. This is seen through policy and practice around anti-social behaviour and housing management. There is a reporting procedure that allows for those within the regulated world of social housing to easily report on tenants not behaving as they should. With this comes the expectation that something should be done about the problem as it is a risk to the 'quality of life' of the tenant (Squires, 2008); a concept that successive governments have responded to and another concept that is at risk of being damaged within a community.

The Risk to the community

How a person with poor mental health is defined, whether deviant or someone in need of help, they are likely to be living within a community alongside others who are also exposed to processes of governance and practice. A solid community and what defines it is not a clear concept with many commentators disputing the identity of this collection of individual people. Whereas Durkheim would suggest that solidarity and individualism are intimately connected, Offe disagrees, arguing that individualism dries solidarity out (Crow, 2002). As individuals in a modern society, the aims and needs of the community are superseded by selfish requirements.

There are many reasons a community comes together and remains solid. But what has been emphasised is the breakdown of a valuable and valued

community in which people can thrive and include rather than exclude. The exclusion is illustrated by the 'perceived' risk of the mentally ill to the personal security of the community. However, neighbours within social housing are together through an accident of location. The fact that they live near to each other does not mean that they will interact and ensure the community is embedded (Lee & Newby, 1983). It is the nature of the relationships between people and the social networks, which they are a part of, is often seen as one of the more significant aspects of 'community' *(ibid p. 57).* Being in a social housing community can be difficult with the residue of people coming together with little choice as to where they live.

Two notable and influential authors about community are Etzioni and Putnam. The former is the founder of communitarianism, which pleads for people to attend to their responsibilities, to the conditions and elements they share with the community and it laments that we have too many rights (Etzioni, 1995). Etzioni argues that vulnerable people in society should be helped to advance this social goal, although he argues that this is 'good' and not that it will reduce crime or fear (*ibid p.190*). This can progress the idea of community coming together for more altruistic reasons. Adhering to this philosophy could separate those with mental illnesses from offenders, as both groups have been perceived in the same problematic way within the community. Etzioni maintains that the more unselfish way to view one another will leave only the '*most hardened and criminal persons to the appropriate authorities [and formal social structures] to deal with' (ibid p.193)*.

Although Etzioni's viewpoint has merits, there are issues around helping people that will not, or cannot, be helped. This is apparent within recent research (Savory, 2016). Those displaying ASB, or any kind of unacceptable behaviour, will be excluded through structures set up in the highly-regulated world of social housing if they do not accept support from state-run mental health teams. Although Jock Young was commenting on crime and the underclass in a social exclusion thesis, his analysis can relate to other vulnerable groups as they exclude themselves from society and the community. His work on exclusion puts some of the blame on social structures, the more formal ones being industry and government, that unintentionally incapacitates, or intentionally excludes, individuals (Young, 2012). Other authors have related social exclusion directly to mental health problems (for example Pilgrim, 2017). Even if the community does take on a communitarianism stance, Pilgrim suggests that some social structures, such as lack of employment, hostility from the mass media, poverty and lawful discrimination, would impede any work done to include a vulnerable person (*ibid* p. 201).

Other social structures and their disintegration have been the reason, some would suggest, that we have disengaged from our own local community (Putnam, 2000). What is defined as a social structure by Putnam is the less formal community ones of clubs and activities that bond people together like PTAs and bowling. He proposes the formation of 'social capital,' which involves the regaining of trust and the emergence of norms of reciprocity within social networks of individuals *(ibid, p. 19).* When viewed in a community discourse this can suggest a re-embedding of a group of people, but only when the unity is natural and not forced (Bauman, 1990).

To combine the two concepts of Etzioni and Putnam is to propose that positive communities involve the interactions between people with a sense of belonging, in which they are aware of their social responsibilities, in other words, a community where any vulnerable person can thrive. What is apparent is that the reality of community is different from the view that communitarianism has that we have lost the traditional community and that it should be reconstructed (Etzioni, 1995, p. 116). This has fed into the image policy makers have of a '*golden age*' (Putnam, 2000, p. 24), with the emphasis on 'well-being' and a positive quality of life (see for example The Care Act, 2014). However, Bauman doubts that the community the policies are trying to reconstruct ever existed in the first place (Moore, 2008; p.195). Beck states that we have come a long way from this imagined and ubiquitous family and village community (Beck, 1997). Albeit, whether the social change Beck and others allude to is positively progressive has been assumed rather than proved (Crow, 2002). The golden age can be defined as such by those who are not diverse enough to fit into a twenty-first century community. This returns to the issue of the social construction of what is acceptable and normal

Etzioni's and Putnam's theories serve to contextualise the issue of community that housing professionals work within and their awareness of what is acceptable behaviour within these communities (Parr, 2009). These professionals deliver services that include more than physical improvements to houses and areas. Not only is social housing concerned with the quality of life of individual tenants, but also the reputation of the estate in which they are living (Parr, 2010). The levels of ASB must be reduced for an estate to be desirable. The existing research and literature shows that whilst trying to evaluate the mechanisms for ASB and housing management within the community, the focus has been on short term resolutions rather than trying to work on the root cause (Yau, 2014). Governing problem tenants by way of evictions, injunctions and punitive orders can alleviate the problem for the community where the behaviour is situated. However, this only moves the nuisance from that area, or

prevents it for the duration of the time of the order. The statutory framework favours enforcement methods (Hoffman, Mackie, & Pritchard, 2010), making support difficult for those who may need it. Thus, this route is open to the community as they request a more permanent solution to the ASB they are suffering. Whether the community really wishes a person who is unintentionally anti-social to be punitively treated is under-researched.

More permanent, long-term solutions to ASB lie within the community. Australian research indicates that although a person can be housed in the physical sense, there needs to be methods to address social exclusion from the community (Johnson, Parkinson, and Parsell 2012). Yau found that neighbourhood attachment, or a sense of community, could have the possibility of reconciling social disorder (Yau 2014). The attachment to one's surroundings can also be part of good mental health.

The Risk to the individual

Although recent political rhetoric is to help improve people's quality of life rather than criminalise misbehaviour, (see for example Home Office, 2014), the link between crime and minor disorder is still influential according to the literature (Jacobson, Millie, & Hough, 2008; Newburn & Jones, 2007) and recent empirical research (Savory, 2016). Whilst this connection continues, any person behaving in a way that can be perceived as anti-social will be feared as a would-be criminal. This is so pervasive within the neo-liberal state that it requires a punitive solution to return the individual to the acceptable norm.

Powers and obligations to deal with anti-social tenants are specifically given to social housing providers in various housing acts and the Anti-Social Behaviour Act (2003). Within this act, the housing departments are statutorily obliged to develop ASB strategies. The housing role has been developed within the new Anti-Social Behaviour, Crime and Policing Act 2014, which replaces the Anti-Social Behaviour Orders (ASBO) and section 153 of the Housing Act 1996 housing injunctions with the injunction that is to be used by all policing agencies. Defined within section 2(1) of this act is the matter of whether the person is causing nuisance, annoyance, harassment, alarm or distress in a residential setting or not. This is the main impact for social landlords. It puts them 'on an equal footing with the police and local authorities when dealing with 'housing-related' ASB' (Wickenden, 2014; p4). The regulations that cover those people in private housing are vaguer and less structured. The housing professional is expected to deal with the problematic tenant by the structured legislation and housing policies. As the literature and victim surveys have situated ASB

and crime within areas that social housing professionals have the responsibility to manage (for example Tilley, 2010), it should follow that they will use the punitive measures open to them to fulfil their obligations to reduce the social harm. Those whose behaviour is negatively exacerbated through poor mental health become caught up in the 'net-widening' of the punitive ASB regulations so demanded of the media and the community (Long & Hopkins-Burke, 2015). The risk is to these individuals when the origins of the legislation was to resolve the problem of 'feral, already marginalised, youths' (Squires, 2008; p.58). Whilst those with poor mental health and little family support are more likely to reside in social housing, those managing these communities find that tensions can arise when faced with a situation whereby punitive regulations clash with care in the community (Parr, 2010) when trying to resolve ASB. These tensions include trying to get the support the tenant requires from mental health teams before they reach a crisis point (Savory, 2016). Not being able to do so leaves those with poor mental health at risk from criminalisation of the punitive legislation left to the housing and policing agencies.

Before ASBOs were replaced by the new injunctions, 60% of the total number issued in England and Wales were issued on conviction by the court. Out of the remaining 40% (9651) 93% of them were applied for by the police and local authorities[9]. This leaves just 676 ASBOs applied for by housing professionals from 1999 to 2013. This equates to around 48 ASBOs applied for per year by all the social housing departments in England and Wales. Therefore, applying for a civil injunction like an ASBO was not a common occurrence within housing departments. That is not to say social housing tenants are not the recipients of injunctions and ASBOs. It just suggests these were not a sought-after mechanism of governance by housing staff. However, the number of section 153 housing injunctions sought after by housing professionals and succeeded as a resolution has not altered significantly according to HouseMark reports. In 2009/10 0.8% of resolutions were section 153 injunctions (Wickenden, 2010; p.28). Five years later and after the implementation of the 2014 ASB act, the less punitive injunction was also used 0.8% of the time to resolve ASB (Wickenden, 2015; p.12). This gives evidence that injunctions are utilised, but not to a great extent. However, even though it is a civil mechanism, it will bring into a formal justice system a person who is only causing a nuisance rather than a serious social harm. What is a concern is the inclusion of a Community Protection Notice (CPN). This is a new and

[9]https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/355103/anti-social-behaviour-order-statistical-notice-2013.pdf

punitive measure that give powers to issue the notice to authorised persons that, although not exclusively social housing providers as yet, they can request for CPNs to be issued by the police or local authority. The notice is civil in its issuance, but the breach is criminal. It is similar in this way to the ASBO that was criticised for the criminalisation of nuisance (Squires, 2008). Once again, the individual is prey to the communities demands for the authorities to resolve them of the 'perceived' dangerous element they fear.

Although not the CPN, the government guidance for ASB includes other tools, formal and informal, that are available to housing agencies to manage their tenants (Home Office 2014). Once a problematic tenant has been identified, the legal and punitive avenues housing staff have available to them, other than injunctions, are quite substantial. To prevent ASB, every new social housing tenant is given an assured shorthold tenancy. This is a year fixed term, automatically transferring into a more permanent, assured tenancy if there has been no legal notice seeking possession of the property served in relation to any breach of tenancy conditions. Local authorities have the same mechanism in place, but these are called 'introductory tenancies', which are transferred to secure tenancies after a year[10]. If a problem of ASB does occur by a tenant with an assured or secure tenancy, housing officers can go to court to request a demotion of tenancy[11]. This is where the tenancy can be demoted to an assured short hold, or introductory, tenancy for a year then automatically secured if no further ASB ensues during that year.

These strategies and mechanisms aim to prevent ASB. However, often the only way to permanently stop or move the behaviour from the local area is to evict the tenant[12]. In 2011-12 only 0.03% of the total stock of local authority properties was emptied purely due to evictions for ASB[13]. 9.48% of all evictions during this period had an ASB element to them. This shows reluctance by housing staff to use punitive measures. The reasoning has not been explored within the extant literature save to suggest that the professionals are competing with various policies; punitive and support (Parr, 2010). Especially as the housing professional's role is not only to enforce regulations but to support tenants to maintain their property. However, in recent research it was found that 81.3% of housing staff respondents to a survey have taken enforcement action against someone

[10] Housing Act 1996 Part V ch I.
[11] Housing Act 1988 as amended by Anti-social behaviour Act 2003 section 15.
[12] Housing Act 1988 section 8, as amended by section 151 of the Housing Act 1996, grounds 12 and 14 for those who have secure and assured tenancies.
[13] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/266691/Local_authority_housing_statistics_2012_13.pdf

with known poor mental health (Savory, 2016). This survey was nationwide in England and Wales and there was an ethos of trying to resolve the problem with support. However, when this does not resolve the issue, enforcement and eviction is resorted to with a hope of engaging the mental health services, but risking homelessness for the individual. American research indicates that a homeless person has greater risk of death[14], so this cannot be the most appropriate way to provide the longed-for support.

Research (for example Nicholls & Atherton, 2011) and official documents (for example Department of Health and Concordant Signatories, 2014) have agreed that poor housing can affect a person's mental health and that interventions need to provide support (Tamlyn & Page, 2009) in order to maintain a tenancy. Other literature has concurred to the absence of a stable home being a marker of vulnerability, which leaves the person open to risk (Greenfields, 2012). However, this has not been acknowledged fully within the government Concordant[15]. This sets out how the government supports services working together to help those in mental health crisis by early intervention. Although it mentions housing, for example on page 16 it suggests that housing should contribute to the solutions, no housing official is a signatory of the concordant. It is a mistake to side-line housing organisations and the vital contribution they can make to assist in any early intervention to avoid the risk that the individual will face if accused and investigated for behaviour perceived to be anti-social.

The Equality Act does not allow a person to be discriminated against by evicting them because of their mental disability. However, common law is still in place when housing professionals seek possession orders under the Housing Acts. The landlord would not be discriminating against the disabled tenant if there is an appropriate level of justification. This is set within the precedent case of Manchester City v Romano [2004] EWCA 834 Civ. The health and safety of other neighbours is enough to evict a person with a mental illness that contributes to the anti-social behaviour (Mandelstam, 2013). This is further confirmed in LB Lewisham v Malcolm [2007] (EWCA Civ 763). It gives a clear avenue for housing departments to evict a person even if the behaviour is due to a worsening of their mental health. It also gives power to the community, as they are the ones who judge the behaviour against their own health and safety. It can be suggested that

[14] See http://sacramentostepsforward.org/wp-content/uploads/2013/08/Homeless-Deaths-Report-1-9-14-FINAL.pdf and a follow up report: http://www.dhhs.saccounty.net/PRI/Documents/Sacramento-Medi-Cal-Managed-Care-Stakeholder-Advisory-Committee/Monthly%20Meeting%20Documents/20150427/MA-Homeless-Deaths-Report-20150427.pdf

[15] http://16878-presscdn-0-18.pagely.netdna-cdn.com/wp-content/uploads/2014/04/36353_Mental_Health_Crisis_accessible.pdf

this is an illustration of what Pilgrim (2017) suggests as lawful discrimination.

With these issues in mind, there is a danger of social housing falling back on punitive measures to resolve the complaint of ASB (Parr, 2010). The neglect in policy regarding the difficulties that housing agencies have in these circumstances can cause tension between them and other agencies. Governance, in the shape of solutions, is constructed by these practitioners working with the legislation, victims and perpetrators. Few pieces of literature explore how current policies impact on working relations between agencies and the impact on perpetrators with variable mental capacity. A criticism spelt out by Parr as she discusses the impact of 'social structures' (Parr, 2009; p.370).

Once evicted, it is difficult for the person to access any housing (see Harding & Irving, 2014). Commentators have suggested that the punitive methods do not afford a person the same due process as they would have if they were to commit a criminal act (Squires, 2006). In addition, the interventions may only serve to criminalise the more vulnerable within our society by way of detention through the criminal justice system (Pilgrim & Rogers, 1999), due to their lack of a stable residence. The alternative is entering a mental health system that is under resourced and stigmatising.

What is recognised by practitioners, is that those who fall below the mental health threshold are not being supported in the same way as those who have a more permanent, diagnosed mental disorder (London Councils, 2014). The criteria element of support gives health agencies no requirement to spend their scant resources on people that fall below where support can be offered. To compound the issue further, the lack of training that housing officials have on the topic of mental health in general, means that they will also be unable to supply an appropriate, supportive, service. What has emerged also has been the difficulties housing professionals have when trying to access the support agencies for their tenants (Cooper, Brown, Powell, & Sapsed, 2009). In addition to this is a concern of ineffective multi-agency working (Nixon, Blandy, Hunter, & Reeve, 2003). Although multi-agency working is a tension mentioned in Savory's 2016 research, it is the partnership working with the mental health teams that cause the most problems. Housing staff are more likely to contact the teams when the ASB complaint contains a mental health element, but once it is identified that the individual is not under the care of the state support system, it is left to the housing and other policing agencies to manage the complaint. Tensions arise for a speedy resolution from the community who insist something is done to relieve them of the abnormal behaviour and

perceived danger from the tenant (Savory, 2016). If the individual is not diagnosed they are at risk of being evicted, criminalised and homeless. If they voluntarily enter the support system, they are at risk from becoming stigmatised, excluded and feared by the community they wish to belong to.

Resolution to the risk

What has been discussed so far has been the risk to the community from the individual left to suffer a mental health crisis without support to prevent it. Also, the risk to the individual of stigmatisation and/or criminalisation and/or homelessness and the ensuing negative effects. However, the ASB, Crime and Policing Act 2014 act acknowledges the punitive side of ASBO/CPNs and the risk of criminalisation, with an attempt to include the community in ASB resolutions. Within the 2014 Act, there is an emphasis on the solutions coming from the community. Although there are more regulations for social housing staff to use to resolve misbehaviour within localities. These include a new mandatory ground for eviction for tenants with injunctions to prevent ASB or Criminal Behaviour Orders who have breached their order (Wilson, 2014; p.22-23). Once applied for, the eviction must be granted by the courts. This is an absolute ground for eviction and it does not allow for any discretion by the courts. Within the procedure for this, however, is a review before going to court (Home Office, 2014; p.61). What the review consists of is not clear yet. Nevertheless, the danger is that, not only could the tenant be subject to the justice process, they will also be made homeless. This result could have started with low level ASB that was not intentional. As the laws are subjective to the victim, this probability could be quite high. However, the courts can have a moderating effect on the breaches of orders that could result in imprisonment, as the orders are subject to proportionality, in that the punishment will be in proportion to the transgression (DiRonco & Peršak 2014). Although this is based on the outcome of the case and the subjectivity of the harm done to others, it would still need to be proved. It does give hope that behaviour that is unintentional can be separated from the intentional ASB for the vulnerable perpetrator to be helped. Even so, the tenant must still enter the court system with the landlords being urged to take strong action through investigations and reviews against the perpetrators under the banner of putting the victim first (Home Office, 2014). Not explored sufficiently well are strategies to avoid the court process and the worry of homelessness through eviction.

Diversionary strategies are recommended by Lord Bradley. In December 2007, the Secretary of State for Justice asked Bradley to undertake an independent review to explore the idea of diverting people with a mental

disorder and learning disabilities from coming into the criminal justice system. He was required to make recommendations to the government as to what those diversionary arrangements could involve and what services would be needed to support them. The diversionary action is defined as:

> *"…a process whereby people are assessed, and their needs identified as early as possible in the offender pathway (including prevention and early intervention), thus informing subsequent decisions about where an individual is best placed to receive treatment, taking into account public safety, safety of the individual and punishment of an offence"* (Bradley, 2009; p.16).

Community sentences and community involvement are mentioned in the context of sentencing and diversion. Critics of diversion state it would be ineffective as there is no single agency able to take the lead or be responsible for promoting diversion (NACRO, 1994). Bradley recommends the development of Criminal Justice Mental Health Teams (Bradley, 2009; p.131), going some way to silence these critics. However, once again, the vulnerable person needs to be in the system to get the support.

The issue of resolving anti-social behaviour that includes mental illness and substance abuse, that is dual diagnosis, is a problem that brings out the community insistence that the crime of illegal substance use be dealt with over and above treatment (Savory, 2016). However, as it is an addiction it could be argued that the addiction itself is a mental disorder (Bean, 2001). Bean notes that the increase in substance abuse has coincided with the 'decarceration' movement; some of the mentally disordered becoming drug abusers and some drug abusers becoming mentally disordered (*ibid*). There are specific services that deal with both issues but there are problems when the mentally disordered are dealt with as substance users and the addicted are treated as if mentally ill. Nevertheless, and more worryingly, empirical research indicates that substance abuse is a strong predictor of violence (Pilgrim, 2017). This can encourage communities to ignore the mental illness and focus on the risk that presents itself with this diagnosis.

Dual diagnosis features prominently in Bradley's report with research that echo's studies previously done (for example Regier, Farmer, & Rae, 1990). They illustrate a link between mental health and substance abuse. With this link, Bradley suggests that dual diagnosis should be the norm (Bradley, 2009; p.21). The recommendation that services take dual diagnosis into account may finally recognize this issue and may then decriminalise this section of people and give them the help they need. This is echoed and supported by the Revolving Doors Agency, whose national liaison and

diversion programme was created in response to the Bradley report [16]. This is one avenue the lone social housing tenant could explore when finding themselves in a situation where his behaviour is being criminalised. However, it still requires a trip into the criminal justice system and/or a voluntary submission into support programs with all the ensuing negative issues.

When evaluating the Bradley report in 2014 it was seen that the recommendations of prevention proved to be beneficial (Durcan et al., 2014). Along with improvements in placing those experiencing mental illness in police custody, during the court process and prisons (*ibid*). More partnership working has also meant more chances to intervene at an earlier stage. Research indicates pockets of good partnership working is achieving the aim of prevention where the NHS mental health teams work with housing operatives to manage the tenants in need (Savory, 2016). However, whilst there is legislation and a reporting structure that exists to remove tenants who display ASB, no matter what the cause, there may always be a tension from the community to implement the punitive resolution. A housing team solely devoted to ASB manages more complaints of the subjective unacceptable behaviour than general housing teams do (*ibid*). As legislation and ASB regulations give a structure to what can happen to a person displaying ASB, the same research shows that the existence of protocols between mental health teams and housing can give a supportive structure that anyone can implement. However, the tension arises when the protocols are different. Any protocols must work together for the same aim; the prevention of mental health crisis and maintenance of a tenancy and caring for the person within a community.

Care in the community as a problem emerges with the realisation that the under-resourced support services must be delivered to those in need to enable them to live independently despite their mental disabilities. It is a question of how much the agencies involve themselves in a person's life to enable them to remain independent. Independence is relative, reliant on constructs. Housing is a construct that can limit independence (Allen, 1997). Social housing has various regulations that can be considered by some as an area of 'regulated freedom' (Rose, 1999). These regulations, along with the ASB legislation, control a tenant, with or without a variable mental capacity, and, with that, decrease the freedom of living independently from others. Those with mental health problems, who are being taken care of by the relevant services, have their independence

[16] http://www.revolving-doors.org.uk/health-justice/offender-health-collaborative

limited and controlled under the guise of support through legal means under the mental health legislation (Pilgrim & Rogers 1999).

However, legislation and practice focus on personal choice and assumes that all people have capacity unless proved otherwise. Whilst the Mental Health Act focus is on those in a hospital setting, the Mental Capacity Act 2005 focuses on those in the community and is the main act that the mental health professionals work with (Bartlett & Sandland 2014). This act's principles include *'a person must be assumed to have capacity unless it is established that he lacks capacity'* (*section 1(2)).* Establishment of a lack of capacity needs an assessment by those who are authorised to do so; mental health professionals. No assessment is conducted without a referral from the person's GP, a primary health care service (see for example Bartlett & Sandland, 2014; pps. 43/44). The tenant then needs to attend their doctors, voluntarily. If this is not done, it is left to the housing professional to deal with the behaviour that can impact, negatively, on their workload and the community. Going through the procedure to gain support for the tenant is not straightforward. This illustrates housing professional's complaints that there is a lack of access to appropriate support services found in some literature (Cooper, Brown, Powell, & Sapsed, 2009). The lack of suitable access is a situation highlighted as a big barrier to providing preventative support as a resolution in recent research (Savory, 2016).

The Equality Act 2010 aids a person with mental illness not to be discriminated against when looking for employment and housing (Bartlett & Sandland, 2014; p.31). This act defines the protected characteristic of disability as the person who has a physical or mental impairment, which *has a substantial and long-term adverse effect on the person's ability to carry out normal day-to-day activities* (*section 6 (1);* Equality Act 2010). The onus is on clinicians to diagnose those with a suspected mental condition. To have the stigma of being diagnosed with a mental health problem is likely to prevent some tenants from getting help. The Equality Act applies to any person who refers to themselves as having such a disability[17] and, most importantly, who does not state they have a disability (*Section 6(a) and (b)).* This means that someone with mental health problems may not be in receipt of services that could help them, as they have not declared themselves in need. Although there is an issue of stigma to face, the support to help them through mental health crises is not there without the agreement of the sufferer to be treated.

[17] Although a person may refer themselves as disabled, Schedule 1 section 12 does indicate that adjudicating bodies will take relevant guidance to determine this self-reference.

Conclusion

The article has identified that the concept of mental illness is not value-free and can be considered a social construction. This, despite some commentators suggesting that mental illness is a myth (Szasz, 1974; 2010). With that conclusion comes the aspect of society deciding on what is normal and what is deviant behaviour. Young (1999) and Pilgrim (2017) suggest that the deviants, be they criminals, or people with poor mental health, are the ones that are socially excluded. To be a deviant is to deviate from the norm, of which those with poor mental health do, as they will not or cannot follow a recognised pattern of behaviour. Although much work is being done to break down the barriers of mental health, what is not being considered is the individual thought to be dangerous due to where they live, the lack of a social network, the kind of illness they may be experiencing and how they are exhibiting it.

A main issue identified here is that the individual must voluntarily submit to the state mental health services for the support they can provide. The stigma and isolation felt by those submitting to the label of mental illness can stop them from asking for help before the situation becomes a crisis. For those social housing tenants who live alone, they have no one to identify any changes in their mental health to get help before it gets worse. They have no one to talk to and rely on to help them. However, the concept of a state 'service' can be challenging. As Pilgrim (2017) observes, people are not automobiles, with their problems rectified in a mechanical way. He asks, as does this article, if a service can be imposed on a client (*ibid*. p.119). At present, a support service can only be imposed if the person is a danger to themselves, or another to ensure no one is harmed. The way may not be to impose the state-run mental health services, who according to research (Savory, 2016), are ill-equipped and under-resourced to deal with non-acute mental illness. To care for a person in the community is a laudable aim, if the community will allow for it and not see that person as a risk to their quality of life and well-being.

It can be concluded that the risk to the individual is far greater than the risk the individual poses to the community. The risk of not being properly recognised as having poor mental health means no support. However, the risk of being diagnosed may mean social exclusion. Those who are dangerous are not necessarily those who have poor mental health. Perceiving risk is pervasive in modern life, but this can be due to contemporary developments in increased knowledge. Through the lens of the mass media, an invention of modernity, communities are informed of the possible dangers of certain individuals. The media is a business. They

will provide information that is going to sell, which includes sensationalist stories of crime (Jewkes 2015). Unfortunately, if there is a mental health element to them, the mistaken portrayal can create fear, which in turns associates crime, mental illness and danger (Pilgrim, 2017). However, when a community is faced with an individual that does not fit into the dangerous stereotype, they are not understood. Savory's (2016) research indicates the community will attempt to put them into the dangerous stereotype if the individual does not accept the support that is offered.

Education and awareness of the less dangerous mental health conditions of depression and anxiety has been viewed as a success with royal and celebrity endorsement by way of the influential mass media. Nevertheless, it can be concluded that this goes only part of the way to offer a solution to the lone person living in a social housing flat among a community who fears any person who is different and abnormal. A person who, because of their poor mental health, has not been able to be educated or find work so they can take responsibility for their own mental health. The inroads so far are more directed to those who have the knowledge and the personal infrastructure to take up the help offered. The middle class depressed mother has no stigma attached to her to go to the doctor to accept counselling and anti-depressants. She is not so feared. However, the loner in a crime ridden social housing estate, whose depression leads to bouts of unacceptable behaviour, is so feared.

There are resolutions open to the community to alleviate the perceived risk. These resolutions are more of a risk to the individual. Either a punitive resolution, incorporating ASB legislation that can lead to engagement with a criminal justice system and/or eviction, or the stigmatisation of being labelled mentally ill and living with people who fear the very diagnosis of difference.

The education of the community and support of tenants could start with the social housing professionals, who manage the tenancies and living arrangements of said individuals. With the closing of day centres (Pitt, 2010), private housing providers could close the gap left by providing support and monitoring. Tenants interviewed for Savory's research indicates that the day centre is a big part of their support network. Without it, there is palpable concern about the individual wellbeing if they are to disappear. By providing a physical space and people to help, be they mental health professionals or just a listening ear, it would put the sufferer on the same footing as the middle class depressed mother. The risk to the individual of being criminalised and/or a deepening of the poor mental condition, can be abated. As can the risk to the community of this individual

whose behaviour can only be legally acted upon when it gets to a stage where the community has a right to fear it, that is to say a danger to them. No-one is discussing this individual because maybe they are being managed in a punitive way through ASB and housing legislation. However, this is not ideal and, from the recent research (Savory, 2016), it is not how housing professionals want to manage their tenants. Those tenants who need support and not over-punishing measures, leading to the 'real' risk to the individual of homelessness, albeit lessening the 'perceived' risk of danger to the community.

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