Treatment, deterrence or labelling:

The perspectives of mentally disordered offenders toward the purpose and operation of social and psychiatric supervision

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November 2013
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Abstract

Mentally disordered offenders are a group of service users who experience substantial amounts of control and supervision. This paper uses theories of social control to analyse the way in which the formal mechanisms of control are understood by this group. Nineteen semi-structured interviews with mentally disordered offenders in England who were subject to section 41 of the Mental Health Act 1983 (as amended by the Mental Health Act 2007) provided the empirical basis for this study. Mentally disordered offenders held a number of perspectives on the order. First, the order was seen to act as a mechanism for highlighting those suffering from a mental disorder and for providing appropriate treatment. Second, the order was viewed as a form of disciplinary control through which societal norms might be internalised. Third, the order was seen as labelling offenders in a manner which was experienced as limiting and oppressive. A number of research participants were aware that the order acted to limit staff actions. The offenders who held this view saw the order as a means through which they might shape the support that they received in order to further their own aims. The paper concludes by discussing the meanings given to the order by research participants and by considering the implications for social work practice.
Introduction

The appropriate balance between care and control within mental health services is a hotly contested issue and has developed in accordance to prevailing views on the nature of mental illness. The state has provided legislation to allow for the control of mentally disordered offenders in the UK since The Criminal Lunatics Act 1800, which was brought into place following James Hadfield’s attempt to assassinate King George III (Eigen, 1995). The 1860 Act for the Better Provision and Care of Criminal Lunatics proposed that a further degree of specialism was required in the management of the ‘criminally insane’ which was brought about in part by dilemmas about when it was safe to discharge this group back to the community (Forshaw, 2008). Although The Mental Health Act 1959 established the principles of community treatment, mentally disordered offenders continued to be treated in specialist secure facilities in the UK until the publication of the Reed Report (Reed, 1992). This report recommended that mentally disordered offenders should be treated in the community wherever possible (Jewesbury and McCulloch, 2002). However, whilst community living may appear to offer greater freedom, mentally disorders are often subject to a range of measures designed to monitor and control their behaviour. Mentally disordered who have been made subject to a hospital order with Ministry of Justice restriction under section 37/41 of the Mental Health Act 1983 (as amended by the Mental Health Act 2007) (MHA) may be given a conditional discharge (under section 42 MHA). This has the effect of making them subject to conditions laid down by the Ministry of Justice (MOJ) or a Mental Health Tribunal. Service users subject to this section are required to accept supervision from a social supervisor and a supervising psychiatrist and may be recalled back to hospital by the Secretary of State if they fail to comply with their conditions. The purpose of this article is to consider the views of this group of mentally disordered offenders toward these controls. The article presents original research which presents the different ways that these controls are experienced. In order to contextualise these findings, theories of social control will first be outlined.

Theories of social control have been used to understand how the actions of individuals are regulated by social agents across a range of settings. These theories have been used differently by symbolic interactionists, functionalists, Marxists and post-structuralists in order to understand the way in which social order is defined and maintained (Innes, 2003). These explanations have a broad span, focussing on both formal responses to deviance (such as policing) and on the ways in which individuals are conditioned into accepting particular values (through processes such as schooling). Cohen (2005) has been critical of the breadth of the social order theories and has proposed a narrower definition which focusses on,
...those organised responses to crime, delinquency and allied forms of deviant and / or socially problematic behaviour which are actually conceived of as such, whether in the reactive sense (after the putative act has taken place or the actor been identified) or in the proactive sense (to prevent the act)... (2005, p.3)

Service users subject to section 37/41 MHA are subject to formal legal processes and are thus subject to Cohen’s narrow definition of social control. However, in explaining how they experienced control, research participants often referred to informal processes (such as peer pressure) as well as more formal processes (such as supervision). In order that both of these elements can be examined I begin with an exploration of Parson’s theory of the sick role, followed by debates about different concepts of control including labelling and governmentality theories. A review of previous literature will then outline what is already known about service user views of social control before the methodology and research findings are presented.

**Theories of Social Control**

Sociologists of health and illness have been interested in notions of social control since Parsons (1951; 1975) developed his functionalist perspective of the ‘sick role’. Parsons theory focussed on both the institutional expectations and sanctions toward sickness. He argued that the ‘sick role’ exempted the individual from everyday tasks but that this needed to be legitimated by an authority such as a medic. This exemption is seen to be conditional upon the individual attempting to recover through accessing technically competent help. Scheff’s (1966; 1974) labelling theory has parallels to Parson’ conception of illness in that mental illness is viewed as a deviant status. However, he views mental illness itself as a process of ‘secondary deviance’ in which an individual conforms to a label given by an authority figure. This version of labelling theory can be seen to be problematic for a number of reasons. In line with anti-psychiatrists such as Szasz (1974), Scheff views mental illness wholly as a social construction although he says relatively little about which behaviours may be labelled deviant and why (Bowers, 1998). Critics of this position argue that mental disorder does have a biological basis and in failing to acknowledge this Scheff denies the suffering experienced by both patients and carers (Gove, 1982; Anonymous, 1982). However, an acceptance that mental health professionals and institutions hold a therapeutic function does not mean that they have no role in the social control of individuals. Rather, therapy and social control may be intertwined and complimentary (Scull, 2006).
Governmentality theory has provided an alternative way of thinking about how systems of control may operate within society. This idea was first developed by Foucault (1991) and focuses on the way in which power was exercised within western societies. Foucault charted a shift in the exercise of power from a system in which compliance to the sovereign was enforced through public displays of power to one in which power was exercised by institutions through professional bodies who adopted a more calculative approach to risk. This approach has been applied to psychiatry by Castel (1991) who argues that the profession has developed as an organisational site of power. He argues that psychiatry has increasingly come to exercise control at a distance through the development of an ‘epidemiological clinic’ through which sites of risk are located and monitored at a population level. However, as Godin (2006, drawing on Dean, 1997) notes, the ‘epidemiological clinic’ does not signal an end to face-to-face practice. Rather, mental health services are focussed at those who are perceived to pose the highest risks.

The dilemma about the degree of agency that those with a diagnosis of mental illness may have is echoed in the literature about social work and social control. Recent debate in social work literature has focussed on how far individuals who have contact with social services are subject to social control and how far they choose to engage with services as a process of self-development. Much of this argument focuses on Giddens’ (1992) and Beck and Beck-Gernsheim’s (1991) theories of individualisation which have been applied to child protection social work by Ferguson (2001). Ferguson (2001) argues that social workers are involved with “life planning” in that they assist individuals to resolve the choices and problems that they face. This position has been criticised by Garrett (2003; 2004) on the grounds that Ferguson’s theory underplay the restraining influences of social structure and by Scourfield and Welsh (2003) who argue that whilst service users may be presented with choices, these choices are narrowly defined and are experienced as coercive.

**Service users’ views of control within the current literature**

There is currently no research which has questioned service users directly about their view of the purpose of the order. However, a number of research projects do provide useful insights into service user understanding of control. A key concern for service users detained in forensic hospital is what they need to do to achieve discharge (Rees and Waters, 2003; Godin et al, 2007). Previous studies have noted that service users subject to section 37/41 have a poor knowledge of their legal rights (Goldbeck et al, 1997; Rees and Waters 2003) and of the risk assessments constructed about
them by staff (Dixon, 2012). Although this group of users were acutely aware that their behaviour was closely monitored by mental health staff, it was often unclear to them how such information was used (Godin et al, 2007). Service users often believe that they have to ‘play the game’ in order to be discharged. Views about what this meant in practice varied with compliance being seen variously as taking prescribed medication (Heyman et al, 2004; Davies et al, 2006), changing patterns of thinking (Davies et al, 2006), having successful periods of leave in the community (Rees and Waters, 2003; Davies et al, 2006) or engaging in occupational activity (Heyman et al, 2004; Davies et al, 2006).

Other research has focussed on service user perceptions of the social supervision process (Dell and Grounds, 1995; Riordan et al., 2002; Coffey 2011; Coffey, 2012). Within this literature service users can be viewed to be primarily concerned with the risk that the order may pose to them. Recall was a common worry amongst participants and the rationale for recalls was believed to be very open. In addition to this, restrictions that were placed on service users were seen to prevent them from leading a ‘normal’ existence (Coffey, 2011; 2012). Although service users tended to see themselves as having been deviant in the past, mental health professionals tended to frame them as being deviant in the present (Coffey, 2012). Whilst the intensity of supervision varied, a common complaint was that it was overly intrusive limiting offenders’ ability to re-integrate (ibid). However, it should be noted that responses to social and psychiatric supervision were not wholly negative, with a number of service users citing the benefits of the support received from services (Riordan et al., 2002; Dell and Grounds, 1995).

**Methodology**

The research discussed in this article formed part of a wider project examining the views of service users subject to section 37/41 of the MHA toward risk, risk assessment and the process of supervision. The project was conducted within three mental health trusts in England between March 2009 and September 2011. It aimed to focus on service users perceptions of their own offending risk; their understanding of risk assessments written about them and their perception of the order itself. The research presented in this paper deals specifically with service users’ perceptions of the order.

**Data collection**

The inclusion criteria for the study were that participants must be subject to section 41 MHA.
Potential participant were excluded from the research if they were due to be recalled back to hospital or were identified by their teams as experiencing a high level of distress. The researcher for the project had worked as a social worker in both forensic services and the community. In cases where the researcher had acted as an individual’s social worker, these individuals were also excluded from the study. Ethical approval was gained from the National Health Service (NHS) Research Ethics Committee and from the research committee in each Trust. Participants were contacted with a view to gaining what Bryman (2012) refers to as ‘maximum variation sampling’ in which a researcher aims to ensure a wide variation of cases in relation to their area of interest. A variation of service users was sought in relation to gender, ethnicity and type of offence committed. Thirty eight participants were approached through their care teams of which nineteen agreed to take part. Two of the sample were women. This was roughly equivalent to the proportion of females in the restricted population which was 11-13% between 1998 and 2008 (MOJ, 2010). There were four black participants. MOJ statistics (2010) do not give an overview of service user ethnicity although research by Coid et al’s (2000) indicates a black population of approximately 25% in medium security indicating that black service users were slightly under-represented in this study. All participants were capable of informed consent and consented in writing to both the interview and to the researcher accessing their health and social care records to access risk information written about them. Seven interviews took place in NHS premises whilst the remainder were conducted at participants’ homes.

All interviews were recorded and were transcribed. Coding was conducted using what Coffey and Atkinson (1996) refer to as a ‘code and retrieve’ approach in which data was analysed for concepts and these concepts were grouped together. Narratives were not viewed as uniquely biographical materials but were rather viewed as an instance of social action; that is a site where recurrent social structures and conventions might be recognised (Atkinson and Delamont, 2008). Nvivo software was used to organise and code the data. Similarities and inconsistencies between different groups of individuals were noted and used to refine codes. Emergent patterns were related to the existing literature and similarities and differences between previous research findings were noted which further informed the process of analysis.

**Perspectives on the Order**

All participants in the study realised that they had been placed on a section 37/41 because judges and mental health professionals believed that they had committed a serious offence. Most
understood that they were being dealt with within a legal framework even when they were unsure of the legal parameters. For example, in thinking about what the order meant for him Daniel recalled information given to him by his solicitor. He provided a legal definition stating,

...as I understand, the section 41 is the control by the Ministry and the section 37 determines the mental state...The section 41 actually involves the Ministry of Justice and the fact I should be continually under their direction for, until there is a time possibility of absolute discharge, but not until then would I be free from control of the Ministry.

Whilst not all participants were able to give such a specific explanation as to the framework of the order, all but one was clear that they were being managed within a system that sought to control aspects of their behaviour.

Treatment as rehabilitation

Participants who believed that they had offended as a result of their mental disorder often felt that the section 37/41 MHA was an appropriate means through which their risk might be reduced. For them, this was achieved through professionals monitoring symptoms of illness. In these cases a degree of security was gained through the knowledge that mental health teams were required to provide this support. For example, Adam viewed the level of support he had received under section 37/41 in positive terms. Within his account it was the order itself which provided the framework for rehabilitation and positive relations with professionals. He said,

In fact there are endless benefits, absolutely endless [of being on a section 37/41] because the main thing about mental health is you get cured. You get in the community and you try and live a nice normal life like other people do, being happy and secure. You know all things like that. And the 37/41 actually does that for anyone on it ‘cos they’re monitored...because of the seriousness of that illness and the seriousness of what index offence you did. So I mean there is just no end of possibilities on a 37/41.

Within this account both illness and offending are conceptualised as the problem. Adam’s account of illness has parallels with Parsons’ (1951; 1975) theory of the ‘sick role’ in that it is accepted by Adam and others that this role exempts him from responsibility for the offence. In addition, he believed that he was subject to an expectation that he should recover. The support offered was viewed as positive because it provided the necessary stability for this recovery. Participants who adopted this position were similar to women in Gabe and Calnan’s (1989) research, into women’s perceptions of medical technology who actively chose to apply medical labels to themselves. This is
not to say that Adam viewed all care received uncritically. For example, he complained at length about staff at a rehab hostel and a psychiatrist there who had recalled him. When asked as to how he squared this experience with his positive view of the section he stated:

But this recall was totally different and wasn’t the rules of my section, there was no broken rules, there were no rules that were ignored and even after I had been recalled I still agreed with section 37/41 as it was a personal view between me and my doctor.

Within Adam’s account, the cause of the deviant behaviour in need of correction was seen to be mental illness. Adam’s medical and social care records do demonstrate tension between professionals over the correct definition for his actions. His rehabilitation team had requested his recall, whilst the forensic and hospital psychiatrists viewed this action as unwarranted. What was significant for Adam was the interpretation of deviance by these parties. He objected to the way that his rehabilitation team treated him stating that they judged him according to his offence rather than his illness. In doing so he was not objecting to the form of control but to the type of deviant label being applied. Part of Adam’s disagreement with his rehabilitation team centred on his perceived willingness to engage with rehabilitation activities, such as attendance at work programmes. In addition to this, concerns were expressed by the rehabilitation team about his levels of aggression. Adam complained that his rehabilitation team had not taken into account the level of sedation that he was experiencing from his medication and felt that the demands placed on him by his rehabilitation team were unreasonable. The actions of this team were contrasted against the doctor who treated him following his recall who was seen to respond more appropriately through dealing with the issue of sedation. In other words, the purpose of supervision was seen by Adam as the provision of stability through monitoring, but the effectiveness of this process was reliant on staff framing his behaviour as socially deviant as a result of illness. Supervision was not seen to be constraining in itself and if used correctly was seen to be a tool that could enable integration and recovery. This contrasts with the view of other participants who emphasised supervision as a means of instilling internal discipline.

**The order as a disciplinary control**

A significant proportion of participants believed that the purpose of the order was to instil and maintain a certain type of thinking. However, unlike participants in previous research (Godin et al, 2007; Coffey, 2012) one group of service users that I interviewed were more positive about both the conditioning experienced in hospital and the threat of recall. In order to explore this perspective I
will outline participant views on the form that this conditioning took, their views on the purpose of such conditioning and how recall acted to maintain this.

Participants who valued the disciplinary control offered by section 37/41 MHA gave a range of examples of forms of conditioning within forensic settings. Within these accounts service users were rewarded or punished for exhibiting certain behaviours. For example, Michael spoke of staff in a high secure hospital placing patients in an intensive care ward if they crossed over a painted line on the floor. This ward was viewed as violent, unpleasant and difficult to leave. When asked to explain the rationale for not crossing the painted lines on the floor Michael stated that the purpose was to see whether you could ‘abide by the law’ and that this would indicate to staff whether you could be trusted to abide by rules in the community. Michael believed that his level of risk had reduced as a consequence of such regimes. When asked whether he remained a risk he said,

Michael:....I wouldn’t say that I’m a risk, but everyone’s got some danger inside them...It’s how you learn to deal with it. I learn how to build bridges over mine, tunnels under it, or whatever. I learn how to do all that. And like I say, I’m not the man I used to be before now. I’ve been rehabilitated. So it’s a, I’m not artificial, um, but some of my ideas was drummed into me.

Within this account rehabilitation has parallels with theories of governmentality (Gordon 1991; Dean 1997; Rose 2002), in that hospital regimes were seen as being intended to make service users internalise forms of behaviour which were viewed as acceptable by experts. As outlined above, this system is seen as bringing about a change in behaviour through encouraging individuals to become responsible for their own behaviour. Michael saw himself as adopting new ideals and values which he believed helped him to navigate around risk behaviours. However, it should be noted that this system was not viewed as being distant and impersonal. This poses a challenge to Castel’s (1991) notion of governmentality which sees risk as being managed at a population level as well as Feeley and Simon’s (1992) theories which posit that rehabilitative ideals have been over-run by a generalised risk discourse. Feeley and Simon have argued that new forms of governance have given up on trying to change individuals and have instead focussed on containing high risk populations. Whilst service users in this research did identify that their teams were concerned to reduce their risk it is important to note that these ideas ran alongside notions of rehabilitation rather than replacing them. In Michael’s account this form of rehabilitation was seen to be forceful and he notes that new ideas were “drummed into me”. Nonetheless, these strategies were seen as individual to him and were constructed with his needs in mind.
Whilst recall was viewed to be a negative outcome, the threat of recall was also seen to be a useful deterrent by this group. Notably, all participants in this group had suffered from drug or alcohol addiction in the past and recall was seen as a means to avoid such behaviour. Although these participants were aware that the order restricted their degree of liberty, the majority felt that the order acted as a positive deterrent and that this outweighed negative factors. In stressing the value of deterrence, these participants were presenting perspectives which echoed with themes of governmentality in that those deterrents were seen as a means to help them to internalise more socially acceptable forms of behaviour. Expert systems (in this case their conditions) were then seen as a positive means through which risk avoidance strategies could be defined. The pursuit of these strategies was viewed as being in their best interests. An exception to this was Ben, who showed a greater degree of ambivalence. Whilst noting that the order discouraged him from using illicit substances which might have harmful effects, he also noted that his level of autonomy remained low due to an incident of domestic violence with his partner which had caused the MOJ to become concerned. In this respect his observations were similar to Dell and Ground’s (1995) sample, who were often unhappy that supervision was not reduced over time.

**The order as labelling**

A third group of service users in my research concurred with participants in Coffey’s (2011) research in that supervision was seen as restricting the construction of ‘normal’ identities in a wholly negative way. This group of service users did not think that they suffered from a mental illness and the order was seen to limit their action in unwelcome ways. These participants were making similar claims to labelling theorists outlined above (Scheff, 1966; 1974). Three participants saw resistance to the label as being responded to through punishment. For example Francis stated,

I would be daft to argue because they would lock me up again and say I was ill like they did years ago. If I was to tell the truth and say ‘oh fuck off out of here I don’t want you in my flat, it’s like you are poisoning me’, which is the truth, they would then say I was getting all agitated and don’t think I was very well and say I should be in hospital and stuff.

In this case, intervention from a mental health team was seen to be a form of coercive control in that recall was seen as likely should Francis fail to agree. Similarly, Tony believed that he was a magician but was aware that this belief was interpreted as delusional by staff and so chose not to voice it to them. What is notable is that these participants did not adopt the deviant role, as
theorised by Scheff. Rather, the order was seen as a means to portray them as a particular category of person and participants learnt to pay lip-service to this in order to maintain their freedom. Rather than adopting the deviant role as envisaged by Scheff they responded with secrecy and withdrawal (as proposed by modified labelling theorists such as Link et al., 1989). In addition to responding with secrecy interviewees also voiced the view that they had suffered a ‘loss of self’ as a result of their diagnosis (Charmaz, 1983). In this way, the section was experienced as repressive. Identifying the ways in which participants understood the purpose of supervision goes some way to explaining their responses to it. However, whilst service users clearly saw themselves as subject to processes of control this did not mean that they felt that they had no control at all. The following section will explore ways in which service users felt that they could use the order to their own advantage.

Social supervision as a means of individualization

As stated above, research into service users’ views on supervision shows that supervision may be experienced both positively and negatively (Dell and Grounds, 1995; Riordan et al., 2002; Coffey 2011; Riordan et al., 2006; Boyd-Caine, 2010). Where research has identified service users’ dissatisfaction it has often focussed on the intrusive nature of supervision or on the way that ordinary experiences may become medicalised (Godin et al., 2006; Coffey, 2011). Whilst I do not seek to question the validly of these findings, I present alternative perspectives here which emphasise that service users may also see themselves as having a larger degree of autonomy than has previously been acknowledged.

Arguments about social control within social work have often focussed on whether service users are able to engage with ‘individualised life planning’ in which service users make informed decisions about their involvement with social care agencies (Ferguson, 2001) or whether they are subject to a form of social control which severely limits their agency (Scourfield and Welsh, 2003). Unlike the participants in Ferguson and O’ Reilly’s (2001) research, service users subject to section 37/41 cannot be said to have voluntarily engaged with services, having already been made subject to an order by a judge. However, the issue of agency can be examined once they have received a conditional discharge to the community. I have argued that service users tended to fall into one of three categories which I have outlined above. In cases where service users did not believe that they were mentally unwell the order was seen as repressive in the manner outlined by Scourfield and Welsh (2003). However, a number of service users who did not fall into this category felt that they had some control over the order.
Service users who are subject to a conditional discharge may be given an absolute discharge by either the Ministry of Justice or a Mental Health Review Tribunal. This group of service users are not given an automatic tribunal if they do not apply for one themselves. The service users who felt a degree of agency over their section were aware of this and felt that they had a good chance of being discharged in the near future. In these cases the service users felt able to utilise the order in order to control the actions of their teams. Two participants in the study had been unable to access mental health support prior to being detained under the section. For these participants the order had the welcome effect of guaranteeing continued support. Both Adam and Grace recounted that their team had encouraged them to apply for Mental Health Review Tribunals in order that they could receive an absolute discharge. Both had approached these appeals from their teams with a degree of caution. Grace said:

... they [mental health team] said it’s very unlikely I’ll get off on the first one [Mental Health Review Tribunal] but we will go for it anyway and I think I will tell them when I’m ready. At the moment everything is great. I’m getting the support. If I do go to the tribunal and get off my section I will lose all that support and there is a higher risk of me re-offending without that support if you know what I mean.

In some respects Grace is similar to some of the service users in Dell and Grounds’ study (1995) in that she wished to maintain contact with her supervisors once supervision had ended. However, she was sceptical that such support would be offered should the section be withdrawn and saw it as guaranteeing such support. Grace was aware that her team wanted her to be discharged from the section but felt that she required services and was able to refuse to apply for a tribunal as a means of preventing this. In doing so she was able to exercise a degree of control over staff. Similarly, Michael stated that he wished to remain on the order for the time being both because it acted as a deterrent from drug taking and because it guaranteed that he would be placed in supported accommodation (which he felt prevented him from falling in with bad company). He stated that he wished to be re-housed near to his family and noted that social supervision would make sure that appropriate accommodation was found. He noted that presence of the order would require a new social supervisor to be appointed once he had moved. Whilst he hoped that the order would be lifted eventually he had made a conscious decision to delay an appeal until he had been re-housed. This type of engagement with the order can be seen as a form of ‘individualised life planning’ (Fegurson, 2001). In these cases service users felt able to utilise the order in order to minimise their
own risks. These interviewees were not naïve to the possibility that a supervisor might order their recall or that they might have to work with a supervisor who they did not get on with. However, they were aware that as well as constraining their actions, the order also acted to constrain the actions of staff and that it could be used tactically in this way.

Discussion and Conclusion

This article has addressed the question of what research participants felt the purpose of supervision to be and their attitude toward it. It has demonstrated that service users’ perceptions of the control function of supervision are complex incorporating a wide range of experiences. Participants’ views on the validity of the medical label had a significant effect on the way that the order was experienced. As in Coffey’s research (2011, 2012), illness was often used as a form of mitigation and through drawing attention to the role of medical treatment, some participants sought to frame supervision as supportive rather than coercive. In these cases the therapeutic aims of treatment were seen to offer appropriate controls. These legal controls were viewed less favourably where the focus of supervision departed from what were understood to be treatment objectives. In other cases supervision was presented as a means through which behaviour might be monitored and this was often seen to be supportive. Although the minimisation of risk was seen to be a central purpose of supervision, this focus on risk was not seen to override rehabilitative objectives as a number of authors have suggested (Feeley and Simon, 1992; Webb, 2006). Rather, rehabilitation and formal social control were seen to be intertwined. This is not to argue that service users misunderstood or overlooked the coercive aspects of supervision. Service users were in no doubt that supervisors might choose to recall them and generally saw this as an undesirable outcome. Nonetheless the order was seen to offer some benefits. The group of service users seeking to reject medical labels did so because these labels were perceived to be stigmatised. However, their ability to resist these labels challenges Scheff’s theories labelling theories. Rather than internalising and incorporating a ‘mentally ill’ identity this group responded through adopting what Werth refers to as ‘surface compliance’ (2012). That is they chose to give the appearance of accepting professional ideologies whilst maintaining a degree of resistance. In some cases they sought to educate others thereby acting to reduce the stigma experienced at a societal level. However, it should be acknowledged that they did not believe that this would lessen the type of control that they experienced. Although many of the service users that I interviewed highlighted the limited power that they possessed this was not the experience of all. Some service users showed awareness that social supervision acted to
limit staff responses and believed that the order provided them with the means to reflexively plan their lives in line with Ferguson’s theory (2001).

The research findings have a number of implications for social work practice. Service users subject to section 37/41 MHA are supervised by social supervisors and psychiatrists in the community. Whilst the Ministry of Justice (2009) guidance to social supervisors acknowledges the need to facilitate community re-integration risk concerns can be seen to predominate (Dixon, 2010). Supervisors are required to grapple with the difficult balance between care, cure and control when managing this group of offenders. However, getting the balance right between these competing priorities can cause practitioners a fair degree of angst. Social work has always has struggled with dilemma of how to balance partnership working with the assessment and management of risk (Howe, 1994). Associated with this is the concern about how far service users can be enabled to make true and autonomous choices within supervisory relationships. Much of the discussion of this use of power within social work has focussed on the degree to which professional power might be experienced as oppressive. The findings of this research indicate that social workers may be able to take a more hopeful view toward practice. Previous research indicates that service users subject to section 41 may disagree with workers about their own level of risk and consequently may avoid showing open resistance (Coffey, 2012; Dixon, 2012). Nonetheless, service users within this and previous studies have viewed the order as being both enabling as well as oppressive. This indicates that rather making theoretical assumptions about the way in which power is experienced by service users, social workers need to investigate the way in which the order is understood by those whom they are working with. Whilst this will not wholly negate the difficulties involved with balancing partnership and protection it should provide a clearer view about the areas where partnership might be established.
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