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Treatment, deterrence or labelling: Mentally disordered offenders' perspectives on social control

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 mechanisms of control are understood by this group. Semi-structured interviews with mentally disordered offenders in England who were subject to a restriction order under the Mental Health Act 1983 (as amended by the Mental Health Act 2007) provided the empirical basis for this study. Mentally disordered offenders had a number of perspectives on the restriction order. First, the restriction order was seen to act as a mechanism for highlighting those suffering from a mental disorder and for providing appropriate treatment. Second, the restriction order was viewed as a form of disciplinary control through which societal norms might be internalised. Third, the restriction order was seen as labelling offenders in a manner that was experienced as limiting and oppressive. A number of research participants were aware that the order acted to limit staff actions. These participants saw the order as a means by which they might shape the support that they received in order to further their own aims.

Introduction

The appropriate balance between care and control within mental health services is a

hotly contested issue and has developed in accordance with 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 by

'forensic mental health services' in specialist secure facilities in the UK until the

publication of the Reed Report (Reed, 1992), which recommended that mentally

disordered offenders should be treated in the community wherever possible. Whilst community living may appear to offer greater freedom, mentally disordered offenders who are discharged under section 41 of the Mental Health Act 1983 (as amended by the Mental Health Act 2007) (DH, 1983, 2007) (MHA) remain subject to a range of measures designed to monitor and control their behaviour in the community. In order to understand the form that such management takes we need to consider the current admission criteria for offenders and how they impact on discharge arrangements. In cases where a court is satisfied on the basis of medical evidence that an offender is suffering from a mental disorder they have the option of making that offender subject to a hospital order under section 37 of the MHA. In these cases, the service user is placed within the custody of mental health services and the Ministry of Justice (MOJ) has no further input into the terms of their detention. However, in cases where the court believes that an offender poses a risk of causing 'serious harm' to the public then they may also impose a 'restriction order' (under section 41 MHA). The effect of such an order is to make the service user's discharge, leave and transfer from hospital subject to permission from the Secretary of State. Service users subject to a restriction order may be given conditions by the MOJ or a Mental Health Tribunal at the point of discharge (section 42 (2)) (known as a 'conditional discharge'). Where service users are discharged in this way they receive supervision from a 'social supervisor' (commonly a social worker or community psychiatric nurse) and a 'supervising psychiatrist' who report to the MOJ. In cases where a service user fails to comply with their conditions, the MOJ may recall them when they deem it necessary to protect the public from an 'actual or potential risk' and that risk is linked to the service users' mental disorder (MOJ, 2009, para 5).

Research indicates that service users subject to a restriction order are aware that they are heavily monitored in the community and are subject to recall (Chiringa et al, 2014; Dell and Grounds, 1995; Coffey, 2011a, 2011b, 2012). There is a division among service users in existing studies as to how this control is experienced. Service users interviewed by Dell and Grounds (1995) and Riordan et al (2002) noted some positive aspects of supervision; specifically that a restriction order was seen to guarantee aftercare in the community and gave them access to emotional or medical support from supervisors. Participants in these and later studies (Chiringa et al, 2014; Coffey, 2011a, 2011b, 2012) also noted negative aspects of supervision. These service users stated that the intensive nature of supervision acted to limit community re-integration in that they were forced to declare their status as mentally disordered offenders to potential employers, landlords or future partners. In addition, the grounds for recall were perceived to be very open and the level of monitoring was not perceived to reduce over time. Notably, participants in later studies (Author, 2012; Chiringa et al, 2014; Coffey, 2011a, 2011b, 2012) drew attention to the way in which mental health professionals were pre-occupied with identifying and managing risk. Whilst service users were aware that risk assessments about them existed they reported being unaware of their content (Author, 2012). Furthermore they believed that they were used defensively by staff which in turn limited their efforts to re-integrate into the community (Chiringa, 2014; Coffey, 2011a, 2011b, 2012). Whilst existing research has focussed on service users' experience of supervision or on processes of resistance there is limited evidence of what service users believe the purpose of a restriction order to be. The rationale of this paper is to examine the nature of control from the perspective of the service user. In doing this the paper

draws on theories of social control in order to examine how power is seen to operate and the extent to which individuals believe that they can exercise personal agency.

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 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 (1985) 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 has been identified) or in the proactive sense (to prevent the act)... (1985, p.3)

Service users subject to conditional discharge 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, then describe the debates about different concepts of control including labelling and governmentality theories before presenting the methodology and research findings.

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 legitmised by an authority such as a medic. This exemption was seen to be conditional upon the individual attempting to recover through accessing technically competent help. Scheff's (1966, 1974) labelling theory has parallels to Parsons' conception of illness in that mental illness is viewed as a deviant status and that medics have a key role in identifying and categorising such behaviour. Scheff argued that societies have 'residual rules' that can be understood as unstated behavioural norms. Where an individual breaks such rules, this behaviour may either be ignored or be made subject to a diagnosis. Scheff contended that a process of secondary deviance then took place in which the individual was compelled to accept the label through societal pressure and eventually came to internalise the characteristics of a 'mental patient'. However, this version of labelling theory can be seen to be problematic. As Bowers notes, Scheff downplays individual agency, positioning the person receiving the label as, 'an actor fulfilling the expectation of others' (1988, p.22), whereas individuals may seek psychiatric help because they are experiencing distress and view mental disorder as an objective reality. In these cases, psychiatry can be seen to have a therapeutic function in that individuals see medical treatment as a means to reduce their suffering. Alternatively, individuals may use their agency to reject or resist psychiatric labels, as is the case with psychiatric 'survivors'. However, to accept that psychiatry has a therapeutic function for some is not to argue that it has no role in social control. Whilst psychiatry may act to reduce the distress experienced by

individuals, it also acts as a form of control by defining normalcy and appropriate responses to diagnosed mental illness (Scull, 2006). The goals of therapy and social control therefore may be intertwined and complementary.

Governmentality provides an alternative perspective on how mechanisms of control may operate. The theory was first developed by Foucault (1991) and gives a historic account of the way power is exercised in western societies. Foucault charted a shift from a system in which compliance to the sovereign's rule was enforced through public displays of punishment to a more complex form of government wherepower is increasingly devolved to a range of professionals. Within this system, professional knowledge and techniques act to govern human experience by shaping the way that problems are understood and providing techniques to address them. Drawing on Foucault's theory, Castel (1991) argued that the identification and reduction of risk had become the central concern of psychiatry with risk being increasingly measured and monitored at a population level. Rose (1998) has argued that rather than indicating a de-personalised system, Castel's theory shows how professional subjectivities may be shaped by an overriding concern with risk management. Within mental health services, these subjectivities may be shaped by managerial procedures such as 'clinical governance' or law and policy which increasingly aims to standardise professional decision making (Brown and Calnan, 2012). Such systems act to prioritise the provision of mental health services toward those service users deemed to pose the highest degree of risk to themselves or others (Rose, 1998) with the aim of making individuals take responsibility for managing and reducing their own levels of risk (Rose, 1999). These individualised responses may be allied with new processes of advocacy and legal protections (Fine, 2005). For mental health users,

the right of an individual with complex needs to receive a personalised care plan might be seen as an example of this (DH, 2008), although the degree to which service users can be empowered to take reflexive decisions within such frameworks remains open to question (Hoggett, 2001).

Methodology

The research discussed in this article formed part of a wider project examining the views of service users subject to conditional discharge 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 restriction orders. The research presented in this paper deals specifically with service users' perceptions of restriction orders.

Data collection and analysis

The inclusion criteria for the study were that participants must be subject to section 41 MHA (a MOJ restriction order). Potential participants 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 with respect to gender, ethnicity and type of offence committed. Thirty eight participants were approached through their care teams of which nineteen agreed to take part. Details of participant gender, age, ethnicity, index offence (the offence leading to imposition of the hospital order) and legal status are given in table 1 below. 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. Interviews were conducted using a semi-structured format. All interviews began with an 'introducing question' (Kvale, 1996) in which participants were asked how they came to be made subject to section 37/41 MHA and why the judge in their case felt this was necessary. Participants were asked about their attitudes towards conditions, their views on the purpose of supervision and the effects that conditional discharge had on the way in which professionals interacted with them. They were also asked for their views on professional roles, risk assessment procedures and the way in which staff sought to manage identified risks. Participants were encouraged to describe and expand on their experiences through my use of 'interpreting questions' (Kvale, 1996) in which I sought to clarify an interviewee's interpretation of events by paraphrasing their responses and through using non-verbal cues. The length of interviews varied, with the shortest being 20 minutes and the longest being 100 minutes.

[Table 1 here]

All interviews were recorded and were transcribed. Coding was conducted using a 'code and retrieve' approach in which codes were used as a means to identify common phenomena, collect examples and to analyse those phenomena in order to identify common themes, differences and patterns within the data (Siedel and Kelle, 1995). Initial coding focussed on participants' views of their own risk and participant views on professionals' response to risk and risk assessments. Further analysis was conducted in order to identify sub-codes. When analysing transcripts, I examined the way in which participants used narrative as a means to identify culturally recognised ideas and to relate these to one another. In this respect I was influenced by theories in which accounts are used to examine the ways in which individuals justify and make sense of their behaviour (Sykes and Matza, 1957; Scott and Lyman, 1967). In taking this approach I wanted to identify 'collective stories' of service users subject to a restriction order; that is, the way in which mentally disordered offenders might use or resist cultural narratives in order to identify how they might be seen as a group (Richardson, 1990). Nvivo software was used to organise and code these data. 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 Restriction Order

All participants in the study realised that they had been given a hospital order with MOJ restrictions because judges and mental health professionals believed that they had committed a serious offence. All but one participant understood that they were being dealt with within a legal framework even when they were unsure of the

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parameters. For example, in thinking about what a hospital order with MOJ restrictions 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.

Though not all participants were able to give such a specific explanation of the legal frameworks that they were subject to, they understood that they were being managed within a system that sought to control aspects of their behaviour.

The restriction order as a means to receive treatment and rehabilitation

For some participants the restriction order was viewed as a means of receiving treatment and rehabilitation. Participants were identified as falling into this category where treatment approaches offered by professionals were viewed in positive terms. Ten participants felt that detention under 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 MHA in positive terms. Within his account it was the restriction order itself that 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 were conceptualised as the problem. The support offered by mental health services was viewed as positive because it provided the necessary stability for this recovery. This is not to say that Adam viewed all care received uncritically. For example, he complained at length about staff at a rehabilitation hostel and a psychiatrist there who had applied to the MOJ to have him recalled back to hospital. When asked how he squared this experience with his positive view of the section Adam 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.

Adam's medical and social care records do demonstrate tension between professionals over the correct interpretation of his actions. These notes indicated that Adam's rehabilitation team, who were community based requested his recall. The forensic psychiatrist in the area and the receiving hospital psychiatrist viewed this action as unwarranted. Part of Adam's disagreement with his rehabilitation team centred on his perceptions of his willingness to engage with rehabilitation activities, such as attendance at work programmes. However, 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. Adam contrasted the actions of his team with those of the doctor who had treated him following his recall. He saw the doctor

as responding more appropriately because he dealt with the issue of sedation. Supervision was not seen to be constraining in itself and if used correctly was seen to be a tool that could enable recovery (which was understood as both a remission of symptoms as well as the achievement of social goals such as housing and relationships).

Whilst participants in this category identified themselves as people who were ill and who required medical or psychological treatment, different accounts were presented as to how they came to this view. Of those who described this process, four participants recounted that they had been assessed by a psychiatrist in custody following the offence. In these cases admission to hospital was seen by participants to have been reached by agreement. Whilst they recognised that the treatment was compulsory, they accepted the diagnosis given and viewed treatment in hospital as providing a better option than prison. In three other cases, participants gave accounts in which they initially resisted treatment but came to accept it at a later stage. In these cases, participants described turning points where they had reached a view that they should accept treatment. For example, Daniel recounted that at trial he had insisted that he had been mentally well and recalled,

> I became physically exhausted and I broke down at the end of the eight days and gave in, effectively. And it was determined as a result of that, that I was unfit. So in actual fact I had, if you like, emphasised my unfitness, if that's the right thing to say, um, by continually contesting that I was well, when in actual fact I was unwell.

In Daniel's case, his acceptance of illness was described as a 'capitulation' in which he made a decision to change his position based on the weight of evidence against him. Participants in this group also described coming to a realisation that some mental health staff wished to help them. Their acceptance that they were unwell was then

seen as a relief, in that they had moved to a positon in which they were able to accept assistance from others (although one participant in this group remained somewhat ambivalent in his acceptance of the diagnosis). These views contrast with the views of other participants who saw supervision as a means of instilling internal discipline.

<u>The restriction order as a disciplinary control</u>

Eleven of the participants believed that the purpose of a restriction order was to instil and maintain a certain type of thinking. Participants were identified as falling into this category where they identified that the function of a restriction order was to instil types of thinking that were not related to treatment. There was some overlap between this and the previous category, with six participants identifying that the restriction order had the dual function of exerting disciplinary control as well as facilitating treatment and rehabilitation. In order to explore participant perspectives on the restriction order as a form of disciplinary control 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 saw the restriction order as instilling disciplinary control 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,

> ...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 was seen as bringing about a change in behaviour through the introduction of punishments and rewards which were designed to change individuals' thinking. As a consequence of this, 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. Whilst Michael noted that staff actions involved the threat of force, leading new ideas to be 'drummed into' him, these strategies were seen as being 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 five participants. Notably, all participants in this group self-reported that they 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 restriction order constrained their liberty, these individuals felt that it acted as a positive deterrent and that this outweighed any negative factors. Conditions were therefore 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 restriction 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 restriction order as labelling

A third group of service users in my research saw the restriction order as a form of labelling. Participants were placed in this group where supervision was seen as restricting the construction of 'normal' identities in a wholly negative way. There was no overlap between participants in this category and the other categories explored. These three participants did not believe that they suffered from a mental illness and saw resistance to the label as being responded to with 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. These individuals saw the restriction order as a means through which they were being identified as a particular category of person. These participants did not believe that their offences had occurred as a result of mental ill health and gave a range of explanations as to the reasons for coercive action from professionals. These explanations rested on the assumed motivation of the MOJ and mental health staff to

exercise measures of control. Francis opined that the professionals sought to label him as mentally disordered because they received material benefit from doing so. He noted that,

> …they [mental health staff] are all getting paid the same though the doctor gets paid more.   They all go along with it so they can get some money out of me, so they can go on holiday and things.

In other words, mental health professionals were seen as being malign and diagnosis and treatment were seen as ways of falsely upholding notions of professional power. Whilst other participants in this category did not view mental health professionals with the same degree of hostility, they were wary of the way in which staff might interpret their actions and consequently remained guarded around them. These participants felt that staff were prone to apply an overly reductive medical model which did not take account of their circumstances. All service users in this category voiced feelings of powerlessness in relation to processes of supervision but also identified ways in which they would be selective about the way in which they presented information to professionals in order to minimise restrictions which might be imposed. In other words, whilst participants 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 participants felt that they could use the order to their own advantage.

The use of the restriction order for personal advantage

Service users within the sample had a high degree of awareness that they were regarded as a potential risk to others by mental health professionals and had therefore been made subject to mechanisms of control. However, whilst all were aware that the restriction order was designed to control their behaviour, four

participants were aware that it also acted to limit staff autonomy.   In three of these

cases, service users were aware that staff wanted them to be discharged but that

such a decision could only be made by the MOJ or a Mental Health Review

Tribunal.   Research has found that service users may experience significant

difficulties accessing mental health services (Kovandzic et al, 2011; Anderson et al,

2013) and participants in this group had experienced such difficulties prior to the

imposition of the restriction order. For these participants the restriction order had the

welcome effect of guaranteeing continued support. Both Adam and Grace recounted

that their team had encouraged them to appeal to the Mental Health Review Tribunal

for an absolute discharge. Both had approached this advice 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 was similar to service users in Dell and Grounds' study

(1995) in that she wished to maintain contact with services once supervision had

ended. However, she was sceptical that support would be offered should the section

be withdrawn. In refusing to apply for a Tribunal she was able to exercise a degree

of control over staff. Similarly, Michael stated that he wished to move nearer to his

family and noted that presence of the restriction order would compel his social

supervisor to arrange for supported accommodation to be provided. Although he

harboured a long-term aim to be discharged from his section he made a calculated

decision to delay any appeals until such a move had been facilitated. This decision

was weighed against the possible negative effects of the more coercive aspects of

the restriction order and recognition that future supervisors might employ a stricter interpretation of MOJ conditions.

Discussion and Conclusion

Mentally disordered offenders subject to a restriction order under section 41 of the MHA are a group of people experiencing high levels of control and supervision. Key themes emerged indicating that participants had widely divergent views on the nature and purpose of such control. Whilst all participants recognised that they were subject to control mechanisms, the purpose of control was viewed variously as a means through which they might be identified as people requiring treatment and rehabilitation, as a means of instilling disciplinary control or as a form of repressive labelling. In cases where participants thought that the purpose of the restriction order was to identify them as people needing medical treatment, the supervision they received was viewed positively. The accounts of participants in this category had parallels with Parsons' (1951, 1975) theory of the 'sick role' in that medical treatment was seen to have legitimised their status as mentally ill individuals. From a Parsonian perspective, individuals may benefit from a diagnosis of mental illness because it exempts them from everyday tasks, although this diagnosis is seen to be conditional on the patient drawing on advice from doctors in order to recover. However, as Coffey (2012) has noted, illness narratives may also benefit mentally disordered offenders by reducing the level of responsibility felt by the offender. Participants in this category did explain their offences as having occurred as a result of their mental illness and diagnosis was valued because it provided such mitigation. However, the restriction order was also seen to alter the dynamic between doctor and patient. From a Parsonian perspective (Parsons, 1975) power relations

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between doctors and patients are asymmetrical and whilst medical views may be challenged, lay-perspectives are generally accepted to hold less weight. The reason why the restriction order was viewed positively was because it was seen to fix the status of these participants in place, with the initial diagnosis given at the point of trial being seen as definitive. Legal frameworks were then seen to obligate mental health professionals to provide treatments as well as placing obligations on service users to access that treatment. This framework was seen to act as a safeguard against individual mental health professionals who might question their status as patients taking appropriate steps to recover. This was illustrated in Adam's case. Whilst Adam noted that the psychiatrist who had been supervising him in the community had questioned whether he was taking appropriate steps to return to work and this led to his recall back to hospital, the restriction order continued to be viewed positively. This was because his status as a mentally ill person was then confirmed by other medics and by members of the Mental Health Review Tribunal, thereby highlighting the reduced power of individual psychiatrists to challenge definitions of illness agreed at the point of trial.

In the case of service users who saw the restriction order as a disciplinary control, stability was seen to be achieved in different ways. The accounts of service users in this group had parallels with theories of governmentality (Foucault, 1991; Castel, 1991) in that individuals saw the order as promoting particular kinds of thinking. Accounts of participants in this category focussed on the disciplinary aspects of care. Hospital routines were seen to educate service users into more socially acceptable forms of thinking. These accounts had parallels with Foucault's (1977) account of the Panopticon in English prisons in that hospital routines based on surveillance were seen as inducing forms of consciousness based on professional ideals. Within

these accounts, compliance to hospital regimes were seen to be indicative of an ability to adopt behavioural norms in the outside world. In addition, conformity was seen as a means through which trust between service users and staff might be established. The observation that forensic mental health regimes aim to promote conformity is not new, with research indicating that compliance is seen as a key indicator of progress by mental health professionals (Coffey, 2011; Heyman et al, 2013). Research has also noted that service users may model compliance in cynical ways in order to achieve or retain their independence (Godin et al, 2007; Reynolds et al, 2014). However, the views of participants in this group differ from previous research findings in that the disciplinary measures described were viewed positively. For participants in this group, external controls, such as MOJ conditions were viewed as measures which helped them to develop new ways of thinking which were viewed more positively than the patterns of thought that they replaced. In addition, the threat of recall was seen to be useful in reminding them not to return to previous patterns of problematic behaviour, such as drug and alcohol misuse. 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 goals and surveillance were seen to be complementary.

In cases where participants saw the restriction order as a form of labelling, supervision was viewed as limiting and repressive. However, rather than adopting the deviant role as envisaged by Scheff (1966, 1974) the participants responded with secrecy and withdrawal (as proposed by modified labelling theorists such as Link *et al.*, 1989). Interaction with mental health professionals were managed through adopting what Werth (2012) refers to as 'surface compliance'. 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 at an individual level. Consequently, this group of service users voiced a 'loss of self' as a result of their diagnosis (Charmaz, 1983) where they experienced their previously valued identities as having been invalidated or restricted.

Whilst participants who saw the restriction order as having a rehabilitative or disciplinary function recognised that the law acted to frame the actions of professionals, four participants felt that they could use this framework to their own advantage. In line with other areas of care (Fine, 2005) mental health services have increasingly adopted individualised care plans (DH, 2008) through which service users are encouraged to reflexively plan their own routes to recovery. The degree to which service users subject to professional supervision are able to engage in reflexive life planning within social care settings has been the subject of some debate. Whilst some argue that service users are able to take calculated risks when engaging with welfare services (Ferguson, 2001), others maintain that the surveillance function of such services leads to the implementation of coercive forms of control which severely limit the agency of service users (Garrett, 2003; Scourfield and Welsh, 2003). Participants in this study recognised that the mental health services had a social control role which gave them a range of coercive powers. However, they also recognised that this duty might be undesirable for professionals who wished for the restriction order to be discharged. Consequently these

participants could be seen to have engaged in a process of reflexive life planning by refusing to engage with appeals for discharge to the MOJ.

Service users subject to a restriction order are subject to institutional controls, which are mediated by a range of mental health professionals. As Lianos (2003) notes (in relation to misinterpretations of Foucaldian theory) institutional controls are often interpreted as arbitrarily negative without adequate attention to their production, reception or content. This paper has focussed on service users' understandings of the purpose of the restriction order. An examination of their accounts reveals divergent views on the purpose of supervision. Medical control has been described as being fundamentally oppressive by some theorists (Scheff, 1966) on the grounds that diagnostic labels bind patients to deviant identities. Whilst this was the experience of one group within the sample, it was striking that other participants represented the restriction order as promoting their interests either through guaranteeing professional treatment or through establishing new ways of thinking. In representing the restriction order in this way participants were highlighting that it not only acted to control their actions but also acted to control the actions of professionals. In doing so, it was seen to promote the interests of the service user group as a whole, although it was recognised that individual professionals might vary in their approach to enforcing the rules. An understanding of the way in which the order limited professional action also enabled service users to use the order to their advantage in some cases.

The findings of this research have implications for the care and management of mentally disordered offenders. Recent research has highlight tensions between

service users and professionals focussing on their differing interpretations of risk. Within these accounts professionals are seen to use professional ideologies as a means of controlling emergent identities of service users (Coffey, 2011; Reynolds et al, 2014). Whilst it is the case that supervision may be experienced as coercive or oppressive, this is not universal. Greater attention therefore needs to be paid to the way in which service users conceptualise the restriction order in order to understand potential benefits from their perspective. An examination of these views may provide the basis for a more intelligent use of power grounded on an understanding of common objectives.

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Table 1 - Details of Research Participants

Pseudonym of Participant	Gender	Age	Ethnicity	Index Offence	Legal Status
Adam	Male	35	White UK	Manslaughter	Conditional discharge
Ben	Male	39	Black British	Assault and Actual Bodily Harm	Conditional Discharge
Christopher	Male	53	White UK	Actual Bodily Harm	Conditional Discharge
Daniel	Male	59	White UK	Manslaughter	Conditional Discharge
Eric	Male	40	White UK	Arson	Deferred Conditional Discharge (after having been recalled from a Conditional Discharge)
Francis	Male	45	White UK	Actual bodily harm and criminal damage	Conditional Discharge
Grace	Female	45	White UK	Arson	Conditional Discharge
Henry	Male	55	White UK	Arson and burglary	Conditional Discharge
Ian	Male	36	White UK	Actual bodily harm	Detained under section 37/41 MHA (after having been recalled from a Conditional Discharge)
Lamal	Male	26	Somali	Actual Bodily Harm	Detained in hospital under section 37/41 MHA.
Michael	Male	52	Jamaican	Manslaughter	Conditional Discharge
Neil	Male	38	Black British	Manslaughter	Conditional Discharge
Oliver	Male	49	White UK	Legal category of offence missing from file, although professional reports make reference to a 'sexual offence'.	Conditional Discharge
Phillip	Male	31	White UK	Malicious wounding	Conditional Discharge
Quentin	Male	47	White UK	Actual Bodily Harm	Conditional Discharge
Richard	Male	34	Polish	Wounding and Grievous Bodily Harm	Conditional Discharge
Sally	Female	39	White UK	Affray and Criminal damage	Conditional Discharge
Tony	Male	35	White UK	Common assault	Conditional Discharge
Vic	Male	36	White UK	Actual Bodily Harm	Deferred Conditional Discharge