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Living 'in between' outside and inside: The forensic psychiatric unit as an impermanent assemblage

Abstract

This paper presents analysis from a study of staff and patient experiences of the restrictive environments of a forensic psychiatric unit. The paper conceptualises the forensic unit as an *impermanent assemblage*, enacted in and through practices that hold a future life outside the unit simultaneously near, yet far. We show how the near-far relations between life inside and outside the unit operate in three ways; 1) in relation to the 'care pathway', 2) practices of dwelling, and 3) creating and maintaining connections to life 'beyond' the unit. The paper concludes with a discussion about possible ways to overcome the limitations to recovery that can arise through practices of impermanence.

Introduction

Forensic psychiatric units exist at the intersection of the criminal justice and mental health systems. They aim to provide a therapeutic environment that facilitates discharge back to the community, while ensuring safety and security (Spiers, Harney, & Chilvers, 2005). Forensic units are one of a diminishing number of institutional spaces as the drive of community care continues to deinstitutionalize mental health (Bennett, 1991; Coid, 1994; Shen & Snowden, 2014). Existing research investigating the role of space and place in mental health has predominantly focused on community settings, often in terms of recovery, such as Duff's (2011) 'enabling places', Pinfold's (2000) 'landscapes of care', and Gesler's (1992) 'therapeutic landscape' (Wood et al, 2015, Lengen, 2015, Piat et al, 2017, Gastaldo et al, 2004).

Studies have also highlighted the importance of belonging (Parr, 2008), social inclusion (Andresen et al, 2011) and the impact on service user experiences of places such as community day centres (McGrath & Reavey, 2016; Smith & Tucker, 2015) and home environments (Tucker, 2012; 2017). The present paper extends research through a focus on forensic spaces, one of the few remaining institutional spaces of mental health care.

An approach developed from assemblage theory will highlight how the overarching institutional practice of orienting to a future life outside the unit makes the 'outside' simultaneously ever-present and distant. The presence of a future life beyond the unit is designed to avoid a sense of permanence on the unit, and yet patients' experiences can be static, particularly when the care pathway fails to deliver a meaningful sense of movement. Empirical analysis of the 'interactional capacities' of the unit unravels some of the ways that patients experience and manage 'movement' in and through the restrictive environment, specifically in relation to the care pathway, the unit as a 'home' and maintaining connections with the outside world. The paper draws on research conducted in a medium secure forensic unit in London, UK, utilising photo-production and semi-structured interviews with patients and staff.

Institutional Assemblages

Forensic psychiatric units are one of the few remaining institutional spaces of mental health care, with the majority of provision occurring through community services. Institutional care is predominantly short-term, for periods of acute crisis, and provided through psychiatric wards in general hospitals (Curtis, 2010). Forensic care is a small but significant part of mental health provision, operating in specialist units, which intersect the mental health and criminal justice systems. Admission is often via the prison system (although patients can be admitted directly), for people who have committed a serious criminal offence (or are deemed at risk of doing so) and are likely considered a risk to

themselves and/or others. Forensic units are designed to deliver effective therapeutic-recovery programmes of care, while ensuring security and risk management (Heyman et al., 2004). Forensic units involve a range of personal (e.g. bedroom) and communal space (e.g. dining areas, lounges, corridors), as well as access to outside space (e.g. hospital grounds, local town/cities). The latter has to be approved (in the UK by the Ministry of Justice) and can be revoked if patients are deemed to behave in contradiction to their care pathway. Although forensic units are designed to be medium-term (2-5 years), a minority of patients stay long-term (10-15 years+) (Shah et al, 2011). The care pathway is the primary mechanism designed to promote and deliver recovery, and a sense of movement and progress towards discharge. Each patient has a care pathway that is designed to meet their specific needs from admission to discharge. Pathways are supposed to be regularly reviewed to ensure they meet patients' changing needs, and commonly involve 'steps down' through levels of security (e.g. from medium to low).

The de-institutionalisation of mental health care has led to moves away from Goffman's (1961) seminal work on psychiatric asylums as 'total institutions', operating according to an all-pervasive model of 'top down' power. The notion of the permeability of institutional boundaries has emerged in studies of non-forensic psychiatric wards, whose porosity is claimed to operate through short patient stays, influx of illicit substances and the expansion of care practices beyond the institution (Quirk et al, 2006). The notion of permeability has extended to carceral geography (Turner, 2016; Moran, 2013) in terms of visitation practices, communication (illicit and legitimate) and movements of illicit goods (e.g. contraband thrown over prison walls/fences). These demonstrate how connected life 'inside' is to the outside world. Quirk et al (2006) suggest that modern psychiatric institutions operate on a permeability continuum, with a greater or lesser porosity of the border between inside and outside. For instance, long-term stays subject to isolation and segregation exist at the totalising end, and short-term stays in which pre-admittance

identities are largely retained offer greater permeability (Quirk et al, 2006).

The issue of permeability is less clear-cut in relation to the restrictive secure spaces of forensic units. In terms of the continuum model forensic settings are at the totalising end. And yet, the 'outside world' is present in the unit in a number of formal and informal ways, (e.g. approved leave, staff entering and leaving the unit, patient telephone calls, smuggling of illicit substances). Questions regarding institutional permeability focus primarily on questions of spatial porosity. These do not highlight how a sense of the temporality of the unit, its level of permanence, come to shape patients' experiences, e.g. how notions and ideas of a *future* life 'outside' permeate the unit. The care pathway orients patients to think about their present life inside as a transitory, and a preparatory stage for a future life post-discharge. It is designed to be a temporary home, and yet patients' temporal experience often hinge on questions of permanence and impermanence. How long will they live on the ward? When will they be discharged? Units are supposed to be transitional spaces, and yet patients do not know when they will be discharged as units do not operate in terms of defined sentences (as they do in prison). The overarching challenge facing forensic settings is delivering the rich and diverse range of potential relations that can facilitate recovery. This includes enabling positive social relations, promoting positive mental health, allowing a sense of agency over one's life and environment to develop – all while ensuring security.

Emphasising notions of permanence and permeability links to efforts to study institutions as multiple and heterogeneous, rather than homogenous spaces operating in accordance to a set of inherent physical properties. This means institutions are not thought of as bounded spatio-temporal entities, but as relational and connected spaces, or *assemblages*. Originating in the work of Deleuze & Guattari (1987), the concept of assemblage relates to the notion of network but does not assume the same notion of fixity. Assemblages are thought of as the connecting of elements that previously did not associate, and for which, there is no pre-determined logic to their connection (DeLanda, 2006). Deleuze states

an assemblage is “a multiplicity which is made up of many heterogeneous terms and which establishes liaisons, relations between them, across ages, sexes and reigns – different natures. Thus, the assemblage’s only unity is that of co-functioning” (Deleuze & Parnet, 2002: 69). Assemblages are non-permanent spatio-temporal configurations of multiple elements, which are not stable pre-configured entities, but actually ‘open systems’, such as bodies, technologies, institutions. Assemblages are defined through external, not internal relations, with no pre-existing internal logic to their emergence. Indeed, assemblages are ‘wholes’ whose relations cannot be fully explained by the properties of their constituent parts (DeLanda, 2006).

Analysing an assemblage requires empirically tracking its relations, which are not fixed as it is not possible to identify in advance the entirety of the possible ways different elements will relate. As DeLanda (2002) notes, “[A]lthough the capacity to form an assemblage depends in part on the emergent properties of the interacting individuals (animal, ground, field) it is nevertheless not reducible to them. We may have extensive knowledge about an individual’s properties and yet, not having observed it in interaction with other individuals, know nothing about its capacities” (p63). DeLanda is referring to individuals, but this idea can be extended to spaces as a ‘whole’ (McFarlane, 2011).

Understanding how an institution operates requires an approach open to its ‘interactional capacities’ (DeLanda, 2006). For example, mealtimes in forensic units are not defined entirely by mechanisms through which they are controlled, namely fixed time and menu. The ways that patients interact with the system, and in doing so, potentially transform it need to be accounted for. An example could be a conflict that arises due to a patient believing they have been given the wrong meal choice, which makes them angrily retreat to their bedroom, kicking chairs over as they walk. Here the fixed property of the mealtime extends beyond the dining area, across a communal area, to the patient’s bedroom. The patient’s distress is grounded in their physical and psychological ‘movement’ emerging

through the interactional capacities of the body-environment at the time. The 'anger' of the patient is not just 'inside' the patient, but exists through the storming off, kicking over of chairs etc. It can also impact on other patients and staff on the unit, e.g. a staff member may become anxious when witnessing the patient becoming angry due to the violent outbursts he has demonstrated previously. Conversely, another patient may secretly be relieved because it shifts attention from their own recent negative behaviour. This paper will analyse a forensic unit as an *impermanent assemblage* enacted through the interactional capacities of patients and the unit in relation to the care pathway, practices of dwelling, and the possibilities for making and maintaining connections with 'outside' space.

Methodological Considerations

The empirical material came from an interview and photo-production project in a medium secure forensic psychiatric unit in London, UK. Interviews were conducted with 20 members of staff and 20 patients in wards across the unit. The unit consisted of six wards; five male and one female. Life inside the unit is subject to the institutional logic of a care pathway that places patients on a temporal journey towards discharge. Each ward has a set of rehabilitative and therapeutic groups, such as anger management, cognitive behavioural therapy, cooking, computer courses, art therapy, etc. Typically, male patients enter the unit on one of the Tier 1 (acute) wards, and then once they have successfully completed the rehabilitative and therapeutic groups on the ward, move to a Tier 2 ward, starting a new series of groups. Given the lower number of female patients, there was only one female ward, meaning admission and discharge operate from the same ward. Patients were provided with a digital camera and asked to take photographs of the unit, supervised by a member of nursing staff. The choice over what to photograph was the patients. Interviews subsequently took place, with photographs used to ground and prompt the interview conversation. The benefit of using photo-production with interviews was that it helped

patients to engage with their feelings and experiences of the unit spatially, with photos providing valuable prompts in the interviews for patients to reflect on their life on the unit. Photo-production is argued to be valuable because photos can elicit rich and insightful accounts from participants (Rose, 2012). In the current study, photos of spaces on the unit prompted patients to talk in detail not only about life on the unit, but also about the many ways that life 'inside' the unit relates to life 'outside', spatially and temporally. The study received ethical approval from the host institution as well as the relevant NHS Trust's Research Ethics Committee. An example floor plan of one of the wards on the unit is included below:

Ward Floor Plan



The analytic process involved a systematic familiarisation and coding stage, beginning with multiple re-readings of the interview transcripts by all authors. This was followed by a stage in which a set of initial themes were developed from the codes. Themes were then double checked against the codes, and cross referenced. This process is most closely associated with thematic analysis, although we also drew on principles of thematic decomposition (Stenner, 1993; Ussher & Perz, 2018). The analysis focused on developing themes that captured patient and staff experiences of the logics of security and therapy across a range of practices in the unit. The analysis was not only focused on the physical

operation of the wards, e.g. in terms of the interactional capacities of patients' bodies, but also how psychological processes of feeling and emotion are made possible in and through the assemblages of the unit. This means understanding that patients' mental health is indelibly linked to the practices that constitute life on the unit, distributed across human and non-human bodies and materialities (Brown & Reavey, 2015).

Analysis

Movement and the care pathway

The care pathway is the mechanism designed to deliver a sense of movement, rehabilitation, and to designate the unit as a temporary home. Alongside the pathway tasks is a requirement to behave appropriately, as misbehaviour (e.g. illicit drug use, violence, aggression) is subject to the punitive measure of moving patients back down the care pathway, and therefore further 'away' from discharge. The temporal uncertainty of not knowing when they will be discharged provides a challenge for patients (and staff) in terms of orienting to the imperative to engage with life outside as a goal, while simultaneously lacking knowledge of when discharge will happen. In the following extracts, we see how the movement created by the care pathway (its interactional capacities) is not always experienced as progressive 'towards' discharge but can actually create a feeling of a 'step back' because of the changes to patient-staff relations that movement along the care pathway can bring.

Extract 1:

Interviewer: How do you think about that? What do you think about that system?

Jason: Um, it's not too bad. The only thing about it is sometimes you're sort of starting – when you get – when you move 'em, you're sort of starting a little bit from

the beginning...

Interviewer: Right.

Jason: ...because – because the team – the team that are sort of the primary nurses change and no one seems to know you. So they have to get to know you a little bit. The notes may be there, reading the notes and stuff, but, um – but it's the team getting to know you and everything. So it's – so you're losing a bit of time there by, um, being discharged. I think it takes – it takes a while. It takes a while. Cos like we're now looking at having a tribunal in September for being discharged, but, er, by the looks of it, I'm not sure if it's being supported or not being supported. But – but then – but then again, if they move, once I have the tribunal, er, for being discharged, they might recommend moving to more secure, which is Sparrow, which is another ward here called Sparrow in the building next door. And once you – if that were to happen, then you'd move in there and be starting all over again

The problem Jason highlights is that each ward operates with distinct barriers to overcome. Instead of feeling like progress has been achieved when moving wards, Jason actually senses a movement 'backwards', further away from discharge. This 'starting all over again' is experienced as a barrier to a feeling of recovery and makes discharge and a future life outside of the unit seem more distant. The interactional capacities of the physical design facilitate movement designed to signify progress, and yet, Jason experiences it as lacking. The pathway logic assumes that passage between wards is relatively smooth and undifferentiated when it is actually a new set of groups, relations and space. This results in failing the requirement to provide "seamless progress along the pathway", as stated by the Joint Commissioning Panel for Mental Health (2013, p 15). This issue is exacerbated by patients being held personally responsible for meaningfully engaging with the care pathway, with any perceived failures (e.g. bad behaviour) subject to punishment (e.g.

removal of approved leave). Part of the problem for Jason is a change in care team when moving wards. Patient-staff relationships are central to recovery (Slade, 2009), and yet moving wards means a new team, who may 'work in different ways'. This can 'slow' progress because patients need to build relationships with a new care team. This issue is echoed in staff narratives, as seen in the extract with Rachel (an Occupational Therapist) below:

Extract 2:

Interviewer: In terms of – not in terms of activities, but in terms of, kind of, the space, but do you think the male patients, just through moving, the act of moving, gets – get a sense of recovery?

Rachel: Yes, it does. But on the other hand, they have to change teams and so, again, they have to get into that process of building new relationships which then, you think, "Well. If somebody's going out into the community, they have to do that anyway," so, um, but perhaps if somebody goes from Spruce to Oak then to Sycamore then to Bay, that's a lot of change and that's a lot of, um, getting to know, um, new staff. But on the other hand, yeah, it does give a sense of moving on. Um, on Laurel Ward, it, um, doesn't stop their rehab; it doesn't stop the Pathway, um, but they, they work with the same team all the time. And sometimes, that's better because, um, patients don't like moving, because they know that their rehab will, will actually slow down for a while until that team gets to know them. Different teams work in different ways, um, some patients find that hard. So, there are a lot of pros and cons to it.

Rachel compares male and female care pathways. Managing the female ward (Laurel) involves the same challenges of a range of need, from periods of acute distress to patients

preparing for discharge, but the care team remains the same throughout. Females can feel the benefit of working with the same care team but have to live in a single ward with a potentially vast range of levels of distress and need. For male patients, movement through wards does not, by definition, engender the kinds of rehabilitative value that the design of the physical environment aims to achieve. Staff can also become frustrated with how movement between wards impacts on male patients' progress, with the transition also raising the possibility that patients feel a responsibility for disappointing staff when 'stepping back' in their pathway. This is not to suggest that such a system does not have value. It does allow patients to work collectively with others deemed to be at a similar stage in their recovery. And yet, the idea that patients are afforded a meaningful sense of progress through the care pathway does not map neatly to the lived realities of interactions between the pathway and patients. These are bound up in a variety of practices, such as the medical notes documenting progress, the relations with staff in the different therapeutic groups and other factors involved in a physical change of space, e.g. new bedroom, new patient relationships. There are multiple elements of a move of wards and negotiating all of these successfully can weigh heavily on the institutional pressure to experience the transition as positive and progressive. The organisation of the male wards suggests a spatial linearity to recovery, as if there are neatly bounded 'stages' through which patients pass. The reality is more complex, with patients' journey not spatially, nor temporally, linear. This relates to the question as to how well the overall operation of the unit prepares patients for discharge and raises the possibility that patients come to feel as if they are being set up to fail.

Paternalism and the care pathway

The organising presence of a future life beyond the 'temporary' space of the unit is designed to help patients recover to a level at which they can manage independently. There are though multiple elements that contribute to the pathway, and consequently patients'

preparedness for discharge. In the following extracts the practices of financial management and the unit as a paternalistic space are described as examples of challenges faced in delivering meaningful recovery:

Extract 3:

Interviewer: So, um, how well do you think living in that kind of environment prepares them for leaving, then, and going back into the community?

Claire: Personally, I think we set them up to fail

Interviewer: Really?

Claire: Yeah

Interviewer: So why do you think that is?

Claire: Er, well, they here, they get - they get, I don't know, £50 a week. They can withdraw a maximum of £60 a week. And if they need to buy anything that they want, they need to put it in writing and then can agree that you have so much. Yeah. They don't - they don't buy anything, even washing soap. So all they do with their - their money is, firstly, er, razors, gel, washing - washing, because if they need to buy clothes, that - that is not - that is not up to the £60 (**Right**) Yeah, the £60 is - is - is for things like, those things. And if, er - if you are preparing something like that to go into the community who's not used to parting with money for - for things for himself, you set him up to fail. Because if he goes out there and he has to buy his own milk and he has to cook his own food and he has to clean his own apartment, it becomes difficult and he'll want to come back. Yeah, he would want to come back.

Extract 4:

Leon: Because some people are just reluctant, and they just want to stay here because

they have to, it's convenient. Then people get out more than the people who are engaging well and then coming back. Because, you know what I mean, we're spending thousands of people – of pounds with people doing groups and then they come back.

Claire works as a nurse in the unit. The day to day practices of security on the unit mean that patients' lives are managed and controlled for them. Meals are cooked and provided, bedrooms are cleaned, clothes are laundered, meaning skills and capacities that are required to live independently, such as paying bills, buying food, cleaning, are potentially lost. Claire presents the unit as paternalistic, as patients are not required to use their financial allowance to provide essentials such as food, heat, shelter etc. An institutionalisation problem exists. The unit operates according to a logic of rehabilitating patients for discharge, but the logic of security means that so much of everyday life on the ward is controlled, e.g. washing, cooking, cleaning. Practices of risk management reduce the interactional capacities for patients to develop skills needed to live independently. This points to the structural issues associated with the care pathway. It does not operate in a clearly defined way for patients, but rather as an assemblage of moving relations, which individualises recovery in a way that is unrealistic. The pathway can act to anchor patients to the space, paternalising them into a secure, clean and warm environment, which may differ to what they have previously experienced prior to admission.

The paternalising is perhaps not seen as a significant problem as the unit is only designed to be a transitory space for patients, one lacking permanence, and yet it can create feelings of stasis. This can increase the possibility that patients become de-motivated regarding discharge, because the failings of the care pathway make a future life outside of the unit feel very distant. The argument is that as the care pathway does not facilitate a realistic sense of a future life outside the unit and operates in a paternalistic sense of

providing an environment in which all everyday needs are taken care of, patients can become institutionalised. There is not a sense of a meaningful future life to hold on to and motivate them towards discharge, and for some, this can mean they become institutionalised to stay on the unit. In turn, this can relate to how feelings of impermanence come to shape practices of dwelling for patients.

Practices of dwelling in the impermanent space of the unit

This section focuses on the notion of dwelling as a response to the tension between the impermanence of the space and its ever-present distance from life 'outside'. This was felt specifically in relation to the personalised spaces of patient bedrooms, which patients are required to think of as a temporary home, but one they do not know when they will move on from. The role of home spaces as 'safe spaces' has been emphasised in the care literature (e.g. Milligan, 2003), particularly for people for whom accessing public spaces can be challenging, e.g. through vulnerability. For patients on the unit, bedrooms can offer respite away from conflicts and tension that can arise in communal spaces, e.g. mealtimes, while watching TV and/or playing games consoles. Bedrooms are designed to provide a sense of privacy, and yet, practices of security operate as much in the personal space of bedrooms as in the communal spaces of the unit, e.g. staff looking through bedroom door windows to check on patients.

Dwelling practices are territorialising, they work to mark out and express space in particular ways. Deleuze & Guattari (1987) consider territorialisation to unfold through 'expressivity', in which an assemblage comes to operate and take a perceivable form. As Anderson & McFarlane note; "[A]ssemblages always 'claim' a territory as heterogeneous parts are gathered together and hold together. But this can only ever be a provisional process: relations may change, new elements may enter, alliances may be broken, new conjunctions may be fostered" (Anderson & McFarlane, 2011, 124-125). Territorialisation

processes are subject to transformation, shaping the experience of space and time through relational activity of bodies and objects in mobile patterns. Assemblages are “finite, but they have no specific or distinctive life-span; they do not have a specific temporality” (Marcus & Saka, 2006, 103). In the following section Patricia, a member of therapy staff, talks about practices of homeliness in relation to patients’ bedrooms as an example of territorialising:

Extract 5:

Interviewer: So overall, do you think their bedrooms here are kind of homely spaces?

Patricia: Yeah, I think so. Yeah. Actually they’re all very - yeah - they’re all very funnily enough - I mean Jack who - I don’t know someone spoke to him - he’s done his up really nice, and James, um, yeah, they’re individual. There’s nothing like - it’s - I, I can’t think of any being where there’s, there’s nothing there, it’s just clothes. They all have their own little knick-knacks and posters, um, and desks obviously with all their work and things.

....

Interviewer: Is that why you think it’s important then, to have this kind of homeliness to their bedrooms?

Yeah, it’s a - well, it’s - they have to have some sort of individual identity don’t they? They have to have some space where they can go, um rather than everything being communal and, you know, everyone walking in and out.

The marking out of bedrooms as having the capacity to engender feelings of privacy is an important part of life on the unit. There are limited opportunities for patients to feel as if they can relax by themselves, away from the controlled environments of the communal areas. The link between individuality and space manifests as the territorialising of bedrooms

as a personal space. And yet, bedrooms are not within the control of the patient, as there are limitations regarding the space itself (e.g. fixed furniture) and permitted activities (e.g. patients not allowed in each other's rooms). A tension exists in terms of the capacities to create a home space in the ward, but to do so without the possibilities usually afforded by such spaces, e.g. privacy and personal control. This is in addition to the issue of impermanence of the space. Key here is the role that objects play in how a sense of home inside the unit relates to a future life outside. Cultural anthropology has taught us a lot about the significance of objects in cultural, and individual, practices of identity and belonging, particularly in relation to creating a sense of home (e.g. Daniel Miller, 2008). For patients, making home is a difficult practice because of the competing demands of living with one's material possessions, but in a space that is designed to be transitory:

Extract 6:

Interviewer: Yeah, so when you, you say homely so I've noticed that you use a lot home like words when you're talking about, so you say.....but what about here do you think makes it a home?

Elizabeth: Oh, one of the things is that a lot of the people here, they have all their worldly possessions with them

Interviewer: Yeah

Elizabeth: Everything that they are, is here, either in the bedroom or in our store room. Um, and so I think that makes it their current home. You know, even though in many ways we don't want them to, to kind of, um, you know, want to think that they can live here forever, cos we want them to progress through here and to move to more independent living. But I think it's a temporary home and for that reason that we should it as comfortable as possible and try and, you know, fudge some of those edges and the boundaries around the harsh security element of the - and the

clinical hospital environment.

This extract from a matron clearly articulates the role personal possessions play as visual expressions of life inside the unit. Objects anchor patients to the space of the unit, acting as transitional signifiers of their status as forensic patient. This distinguishes current institutional practice from Goffman's 'totalising' analysis, in which part of the institutional process was to strip patients of their past identity by removing personal possessions; a dematerialisation of life. For patients, the challenge is trying to retain a sense of the unit as a temporary home, while living in a space with all their possessions, meaning there is no 'material life' outside of the unit to connect with. This can create feelings of permanence. Elizabeth recognises this but sticks to the institutional position of needing to garner a sense that the unit is only a transitory space, which relates to Claire's earlier point that the paternalistic approach of the unit does not adequately prepare patients for life outside. In essence, the material possessions anchor patients to the unit, making a future life beyond the unit feel distant. Patients are left having to develop more generic connections with a sense of homeliness and life outside. For this reason, the organisation of objects on the unit is particularly significant. In the extract below we see how the creation of 'compensatory objects' facilitates a feeling of connection in the present with the world beyond the unit:

Extract 7:

James: (Laughs) Aha, yes. That's my fireplace I've made out of...

Interviewer: (Laughs)

James: ...recycled cardboards.

Interviewer: Oh, that's, that's amazing, so, um, why did you make this, and what does it mean to you?

Um, somebody gave me some long strips of cardboard that was two inches by three inches across and they were about four foot tall. And I thought - looked at them,

and I thought, oh, I could make a fireplace.

Interviewer: (Laughs)

So I, I just made one. And I've painted flames on the background, I've made some cardboard flames, and made a little hearth and then filled it with, um, screwed up bits of black paper yo look like coal.

Interviewer: So why did you want a fireplace in your room in particular?

To make it more homely. This is actually the second one I made. The first one I made went to the gallery on the grounds.

Interviewer: So how does your room feel different now it's got a fireplace in it?

Well, it's fun moving the fireplace around, because you can't –

(Laughs)

You know, it's that wide, so it's fairly big. But you can pick it up and move it to a different part of the room. So the room doesn't always have to be there, it can – you know, you can move it in –

Interviewer: How often do you do – do you move it around?

Um, every couple of weeks. Cos the dust collects everywhere so, you know.

Interviewer: Do you think – does it make you feel more at home, that it's here?

Yes, lots of people have said it looks nice and it's a very homely feeling.

Hmm. So do you think everyone should have one in their room?

Um, I think it fills the space, like a room on the ward, where they could have maybe like this room and have fake fireplaces and comfy chairs, it would just make it feel like you weren't in hospital, like you were sitting in your front room.

So is that kind of with the things that you're making, is that one of the aims?

Yeah, it makes you feel like you're not necessarily in, in a hospital environment, you could be somewhere else.

Photo 1: James's mock fireplace



The mock fireplace (Photo 1, taken by James) is a material strategy James develops to manage the ever-present pressure to orient to a life outside the unit, while simultaneously feeling it as distant. The fireplace helps to de-medicalise the ward space, partially transforming his bedroom into a space that facilitates feelings of home usually not present in the ward. The roaring fire conjures a particular feeling of warmth, home and the family. James thinks that more objects like the fireplace could be created to help “fill the ward space”, much of which feels empty due to its clinical minimalism. The fireplace is not an object that signifies the space as temporary but compensates for a feeling of stasis on the unit. It is a way of territorialising the space, indefinitely, albeit within a limited set of interactional capacities of the unit. Only subtle shifts can happen, such as moving the fireplace when it becomes too dusty, as the possibilities for movement are limited due to the fixed nature of the bedroom, e.g. non-moveable bed, desk, wardrobe etc. There is consequently only a limited agency with which to make one's mark. Moreover, the ability to territorialise can be ward specific, with the more creative work (e.g. James's mock fireplace)

emerging from non-medicated patients on the personality disorders ward. The localised practice of patients to create connections with life outside can also take specific configuration of movement between patients and the fixed materiality of the bedroom space.

Creating and maintaining connections with life outside

This section demonstrates a specific dwelling practice in the restricted environment of a patient bedroom. This is about trying to maintain a sense of connection with the world 'outside' in the present, which can help patients orient to a future life beyond the unit. It is not reducible to the properties of the environment, nor of Derek, but emerges through specific interactional capacities enacted in the space.

Extract 8:

Derek: There's a mirror here which reflects that, so you have the triangular kind of, er –

Interviewer: So that's your contact with the outside world?

Derek: Yeah. So - but I'm lying on my bed, there is a mirror there which reflects what's going on there, so I'm - I'm always reminded of what's going on out there because it's reflected in the mirror, yeah.

Photo 2: Derek's Bedroom



Extract 9:

Derek: So it's - you know, there is - there is some movement. And, er, and here's a gate. There's - but I can see the trees. So when I'm sitting here, I'm looking at - although there is, you know, slight - slightly obscured, you've got fifty percent. It's fifty/fifty. So you've got a fifty/fifty chance so - so I'll make the decision on how far I want to go beyond that. So, um, yeah, that's why I kept it there because I'm sitting here and there's another life here and there's another life there, so whatever's going on here is mirrored out there, so it's a reflection really.

Interviewer: Yes. Yes. It sounds like quite a hopeful - sounds like quite a hopeful connection to make as well.

Derek: Yeah. It's - it's - it's - it's, um, here's an orchard. This is an orchard. I'm aware of it's a hospital but it's a - I'm also conscious of the fact that what's happening here is also happening out there. There's not too - there's not - there's not a different so completely different world. It's not so alien. It's not that different, you know, so - so - so there's a mirroring. And I - and I can experience both.

Photo 3: View from Derek's window



In these extracts the mirror offers a mediated connection with outside space. The mirror can be seen on the left-hand side of Photo 2, and Photo 3 is the view outside of Derek's window. The connection between Derek, the mirror and outside creates feelings of closeness and distance, which relates to the overall sense of the outside world as ever-present yet distant. Feeling too far away can be problematic (e.g. trying to identify pathway out) but feeling too close can also be difficult (e.g. pre-discharge anxiety). Of note is the specificity of the configuration as a way of expressing the interactional capacities of the bedroom space, operating through the relation between Derek, the object of the mirror, the bed and the space, which "are not folded into a pre-existent entity, but rather contribute their affective and relational force to the ongoing modification of that assemblage" (Price-Robertson & Duff, 2016, 64). The mirror is a way of connecting with the outside away from the regulated pathways of the hospital. The connection works as a reassuring presence for Derek, bringing together his sense of the similarity of inside and outside, allowing him to

feel as if the outside is not too 'alien'.

The extent to which Derek wants to engage is intentionally decided upon in terms of how far beyond the starting point of 50/50 he will go. This is determined by the positioning of his body on his bed. He cannot move the bed, because it is fixed, but he can lie in different positions on the bed to facilitate greater or lesser connection. The fifty-fifty balance hinges on a chance of being too exposed to the outside. There is a risk involved, which connecting via the mirror mitigates. The mirror allows some control over how much of the outside comes in, allowing a regulated connection to the unregulated space of outside, which operates outside of formal institutional practices, e.g. rehabilitation groups. The mirror creates a space in which inside and outside can merge, in a safe and controlled way, which Derek retains agency over. It keeps a sense of connection with the outside world present, which avoids it becoming too distant.

Discussion and conclusions

Patients' experiences of the unit are grounded in an impermanent assemblage of changing material and social relations, which have to be navigated as part of everyday life on the unit. The institutional logic of the care pathway looms large as an organising principle, but does not always deliver the aimed for sense of progress towards discharge. For male patients, this hinged on the disconnection of patient from existing care team when transitioning between wards. Care pathways are one way in which life 'outside' the unit is made present, with patients encouraged to hope for and imagine a life beyond the unit. And yet, the organisational pressure of security can present obstacles, e.g. stripping everyday practices involved in maintaining a home space of the feelings of agency and identity they can engender. The care pathway is designed to make the unit feel impermanent, and yet can actually enact a sense of stasis and permanence as it does not facilitate positive capacities associated with movement towards recovery and discharge.

Thinking of forensic units as assemblages highlights the temporal uncertainty experienced through a tension between stasis and movement emerging in relation to the competing logics of security and therapy. The question is not how patients experience the 'top down' power of the institution, as if it operates to organise the space in a universal manner, but rather how the space is constituted as a "complex and changeable arrangement of medical, legal and governmental practices, mixing together nurses, former prisoners, airlock doors, depot injections, charts, televisions, plastic cutlery, cigarettes, staff rotas, sunlight and bedrooms littered with belongings" (Brown & Reavey, 2015, p158). Concentrating on the 'interactional capacities' of the unit directs attention to the possibilities for action that emerge in relations between patients, staff and the material environment that constitute life on the unit.

Rather than think the unit as a space of containment, which 'holds' and controls life inside, it can be defined in terms of the capacities to interact that it affords. These capacities are not just provided by the unit as a standalone entity, but actually come to define ways the space (and time) of life 'inside' relates to the outside world. Relations can be spatial, e.g. approved leave, family visits etc., but also temporal, particularly in terms of the institutional pressure to orient to a future life outside. This relates to questions in carceral geography as to how desistance brings a temporal, as well as spatial, operating of prison boundaries (Turner, 2016). The institutional prerogative to demonstrably work towards a life outside the unit is similar to the requirement in prisons to begin the process of transforming for a non-offending life, post-release, while still in prison. As such, the concept of impermanent assemblage has potential explanatory power beyond the forensic mental health literature.

The forensic unit becomes an institution with distinct social and psychological possibilities, which emerge through the ambiguity regarding the competing logics of therapy and security (as Brown & Reavey (2015) note in relation to 'institutional forgetting'). Practices that are normally linked become disconnected on the unit, e.g. rehabilitative

groups such as cooking classes operating independently of meal times. The latter are subject to significant control to minimise risks such as cutlery being used as a weapon, meaning they do not afford the same kinds of experience inside the unit as they do outside. The tensions created through the co-functioning logics of security and therapy can make it difficult for patients to perceive a 'clear' pathway to discharge and life outside. This can lead to a future life outside the unit feeling both near and far, making it difficult to relate to the home as temporary. We suggest that rehabilitative practices need to expand beyond the care pathway, to understand the broader set of practices that enact life on the unit. A rehabilitation group may help a patient deal with anger issues, but if continued conflict is experienced in another part of the ward (e.g. over lack of meal choice) anger will continue to be triggered. The groups are pockets of activity that appear disconnected from general life on the unit. To be successful, rehabilitation needs to exist beyond just one part of the space, to understand the broader practices involved in living in the unit.

The organizing practices through which patients enact their environments in relation to life outside the unit demonstrate how important it is for connections to remain, but those that currently exist (i.e. the care pathway) often render the outside world a distant reality. The disconnect between security and therapy, as felt in relation to control over domestic activities such as food, cleaning, washing, can hinder not only patients' abilities to live independently, but also their motivation to do so. We suggest that being able to maintain agency over a connection with outside space is important, and that the care pathway in its current form is not necessarily the mechanism to facilitate this. Additionally, maintaining a 'material life' outside of the unit could provide a 'hook' for patients, rather than an anchoring to the unit through insisting all possessions remain with patient in the system. We suggest a more realistic impression of life on the outside balanced with therapeutic/relational activities may better prepare patients for discharge. For instance, ensuring that patients are fully aware of the challenges they may face post-discharge (e.g.

loneliness, stigma), which do not exist in the same ways 'inside' as 'outside'. This could help make the unit less paternalistic, and therefore motivate patients towards discharge.

Recognising the differences between 'inside' and 'outside' may enable stronger connections to be made, which in turn could make the path from inside to outside easier to navigate.

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