

# **Living 'in between' outside and inside: The forensic psychiatric unit as a permeable assemblage**

## **Abstract**

This paper presents analysis from a study of staff and patients' experience of the restrictive environments of a forensic psychiatric unit. The paper conceptualises the forensic unit as a permeable 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 for recovery that can manifest in forensic spaces.

## **Introduction**

Forensic psychiatric units exist at the intersection of the criminal justice and mental health systems, aiming 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 impacts on service user experiences of places such as community day centres (McGrath & Reavey, 2016; Smith & Tucker, 2015) and home environments (Tucker, 2012; Tucker, 2013). The present paper extends research through a focus on forensic spaces, one of the few remaining institutional spaces of mental health care.

A theoretical approach developed from assemblage theory will highlight how the institutional care pathway's rendering of a future life outside the unit the primary organising force 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 is offered as a way to unravel 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 mental health 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. Patients route to admission is often via the prison system (although patients can be admitted directly), in cases where a risk management issue is identified that requires secure in-patient care. 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). Access to outside space has to be approved 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+). The care pathway is the primary mechanism designed to promote and deliver recovery and a sense of movement and progress towards discharge.

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 (Quirk et al, 2006). The porosity of institutional borders 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, 2015; Moran, 2013) in terms of visitation practices, communication (illicit and legitimate) and the porosity of boundaries to movements of illicit goods (e.g. contraband thrown over prison walls/fences). 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. Permeability is not just about access to external environments, but also how notions and ideas of a *future* life 'outside' permeate the unit. For instance, the care pathway orients patients to think about their present life inside as a transitory and preparatory stage towards a future life post-discharge. Permeability is temporal as well as spatial. This challenges the idea that forensic units are just secure 'containing spaces', spatially and temporally disconnected from the outside world. 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). One of the main challenges facing forensic settings is delivering the rich and diverse range of potential relations that can facilitate recovery, including enabling positive social relations, promoting positive mental health, allowing a sense of agency over one's life and environment to develop – all while ensuring seclusion and security.

The notion of permeability links to efforts to study institutions as constituted through the coming together of heterogeneous practices, rather than in accordance to a set of inherent physical properties. This means institutions are not thought of as bounded spatial 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).

Thinking of forensic units as assemblages highlights their simultaneous permeability and restrictiveness, often experienced through a tension between stasis and movement emerging in relation to the competing logics of security and therapy. It also demonstrates how logics of recovery and risk management do not operate synergistically to facilitate recovery, but rather as often-competing tensions, impacting on patients’ sense of progress and feelings about a life outside and beyond the unit. Forensic institutions are constituted through multiple kinds of practices 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). The practices are configured in many different spatial and temporal patterns. The complexity at work exists as the intersection of two dominant external institutional practices, those of the criminal justice and mental health systems. The forensic unit becomes an institution with distinct social and psychological possibilities, which emerge through the ambiguity regarding the competing logics of care 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 completely independent of meal times (which are subject to significant control and restriction), meaning they do not afford the same kinds of experience inside the unit as they do outside.

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 the unit are not defined entirely by mechanisms through which they are controlled, namely fixed time and menu, but in terms of the ways that patients interact with the system, and in doing so, potentially transform it. An example could be a conflict that arises due to a patient believing they have been given the wrong meal choice, which makes them angry and storm off 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. Indeed, it can impact on other patients,

and staff, on the unit. For instance, 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 a set of intersecting assemblages enacted in and through the interactional capacities of the care pathway, practices of dwelling and 'making home' in the unit, and the possibilities for making and maintaining connections with 'outside' space.

## **Method**

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, cooking, computer courses, art therapy, cognitive behavioural 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. This process was 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 study received ethical approval from host institution as well as the relevant NHS Trust's Research Ethics Committee.

The analytic process involved a systematic familiarisation and coding stage, which involved 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. The analytic process also drew on principles of thematic decomposition (Stenner, 1993; Ussher & Perz, 2018). The analysis was theoretically informed by ideas associated with the concept of assemblage, which meant developing themes that captured the operation and experience of logics of security and therapy as distributed, relational and manifest in multiplex practices across the unit. This is not purely an inductive process, as theory and data operate as inter-connected parallel elements of the process. The co-functioning of theory and data constitutes analysis. 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 and rehabilitation. 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 regimented nature of the care pathway offers only a limited engagement with a sense of life 'beyond' the secure setting of the unit. Patients do not have a specified sentence (as they would in prison), and as such are left without a definitive sense of when they will be discharged. The temporal uncertainty implicit in the care pathway provides a challenge for patients (and staff) in terms of how they orient 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 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 as a different assemblage with distinct barriers to overcome. Instead of feeling like progress has been achieved when moving wards, as it is designed to provide, 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 physical design of the ward facilitates the capacity for movement designed to signify progress, and yet, Jason experiences it as lacking. The logic of the care pathway assumes that passage between wards is relatively smooth and undifferentiated when it is actually a whole new assemblage. Patients are 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). Patient-staff relationships are central to recovery (Slade, 2009), and yet moving wards means changing care team, who may 'work in different ways'. The sense of progress through physical movement is countered by the sense of progress slowed when faced with needing 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. 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 relations with other fellow patients. 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 patient 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.

### **Projecting to life beyond the unit**

The organising presence of a future life outside 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. This relates to the success of the unit in terms of creating and/or maintaining skills required to live independently. In the following extracts the practices of financial management and the unit as a paternalistic space are described as examples of failures of the unit:

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, as 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 possibilities 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, but rather as an assemblage of moving relations. These 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. However, it can increase the likelihood of re-admission following discharge, and can also increase the possibility that patients may become de-motivated regarding discharge. This could be because the failings of the care pathway make a future life outside of the unit very distant due to feeling unable to cope outside. Leon talks about patients being reluctant to leave the unit, supporting the view that care pathway does not universally prepare patients for discharge. One interpretation of this is that rehabilitative practices in the unit need to expand beyond the care pathway, to understand the broader set of practices that enact life on the unit. A 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 bounded activities, pockets of activity, which 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. In the following section we see this in terms of practices of dwelling in relation to the unit as 'home', although not affording the capacities of privacy and security that home spaces are generally thought to make possible.

### **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 temporal uncertainty manifests in a number of ways. 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.

Dwelling practices are territorialising, they work to mark out and express space in particular ways. Deleuze & Guattari (1987) consider territorialisation to unfold through a notion of 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 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 of the unit. With so many of the practices strictly controlled, 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 marking out of bedrooms as a personal space. And yet, in forensic settings, 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 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 articulates clearly 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. Elizabeth recognises this, but sticks to the institutional position of needing to garner a sense that the unit is only a transitory space, not a permanent one. This 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) 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. In doing so, James's bedroom is partially transformed 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, which helps dilute the clinical feeling of the space. Additional objects like the fireplace could be created, which would help to "fill the ward space", so much of which has a clinical minimalism to it, which can make it feel empty. 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 as his, indefinitely. The fireplace is not an object that is likely to create conflict and disrupt the ward (e.g. like a television), so it can create feeling of permanency. Subtle shifts are possible, such as moving the fireplace when it becomes too dusty, but 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. 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 between Derek, the mirror, and outside space. It is 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 a 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. It also brings in a sense of movement, in a regulated way. Outside is experienced as an unregulated space. 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 a nexus of changing material and social relations, which have to be navigated as part of everyday life on the ward. The institutional

logic of the care pathway looms large as an organising principle of the unit, but as a co-functioning multiplicity of practices does not always deliver the aimed for sense of progress towards discharge. For male patients, this hinged on the abrupt disconnection of patient to 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.

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. It is these practices that constitute life on the unit. Power is not experienced purely in a top down fashion but is distributed through the multiplicity of practices that make the space, as Anderson & McFarlane (2011) note; "assemblage connotes not a central governing power, nor a power distributed equally, but power as plurality in transformation" (p125). 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. Institutional permeability ensures that connections and relations with life outside remain, even in the secure restrictive environment of the unit. Relations can be spatial, e.g. approved leave, family visits etc. Relations are often temporal, particularly in terms of the institutional pressure to orient to a future life outside. The co-functioning logics of security and therapy can create tensions that 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 assess where the borders and boundaries are; what is 'inside' and what 'outside?' 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 new creative ways are needed to help patients develop/maintain the life skills required to live independently, which would also help make the unit less paternalistic, and therefore motivate patients towards discharge. Finding coherence between the risk management and recovery practices could help to make discharge feel more realistic for patients. For instance, new practices in relation to food and eating, such as involving patients in the ordering of meals. Recognising the differences between 'inside' and 'outside' may enable stronger connections to be made, which in turn could made the path from inside to outside easier to navigate.

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