Peripheral recovery: Keeping safe and keep progressing as contradictory modes of ordering on a forensic psychiatric unit.

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1. Introduction

Figure 1: Forensic unit garden

The space in this photograph is a complex and contradictory one. In the foreground, there is a well cultivated garden featuring a bench, seemingly positioned for quiet reflection. Beds of lavender evoke repose and restoration. Flags indicate a sense of community and celebration. As the eye travels up the image, however, the height of the surrounding fences troubles this peaceful picture. Upon closer inspection these fences are not only high, but hostile and laced with barbed wire. Whether designed to keep the world out, or the users of the garden in, these fences stand in stark contrast to the restorative garden below. Threat of harm, whether past or potential, permeates the space; what else could have necessitated such intimidating structures.

This garden is part of a medium secure psychiatric service in the UK, otherwise known as secure hospitals. These contrasts, between peace and hostility, healing and security, embody in many ways the contradictions inherent in forensic psychiatric spaces. These services sit in between criminal justice and psychiatric services. The most common route for referral is through the criminal justice system, where a patient may be referred straight to the secure hospital on conviction, or later referred from prison. A minority of patients are referred directly from the psychiatric system having been

deemed to be too risky or complex for generic psychiatric inpatient settings (Drennan & Alred, 2012). In the UK, this dual purpose means that such services answer both to the National Health Service (NHS) and to the Ministry of Justice (MoJ). Encapsulated in the photograph are some of the tensions inherent in answering these two masters, having to simultaneously promote recovery and provide security. This space is both a prison and a hospital, and yet also, neither. It has elements of both a carceral (Moran, 2016) and a therapeutic (Gesler, 1992) space.

In this article we will contribute to the literature on carceral and institutional geographies through exploring the complexities of care, control, mobility and stasis thrown up by these tensions in a UK forensic psychiatric unit. We explore these complexities through empirical material gathered with staff and patients on a UK medium secure psychiatric unit. We employ John Law's (1994) concept of 'modes of ordering' to argue for a processual approach to thinking through how commonly identified tensions in these institutions, such as care/control (Philo & Parr, 2019) and mobility/stasis ((Turner & Peters, 2016) are not so much oppositions as layers which can be mobilised to congruent or opposing ends.

1.1 Carceral and institutional geographies

Carceral means literally, of the prison, but has been extended to describe practices of incarceration and punitive control which also exist outside of the traditional prison setting ((Moran, Turner, & Schliehe, 2017). Other forms of detention, such as immigration detention centres, are also understood as being carceral institutions (Gill, 2016) whilst community based practices of the 'new penology' (Feeley & Simon, 1992) such as electronic tagging are understood as an extension of carceral practice beyond the confines of the prison itself. Forensic services can be seen as another type of carceral institution, being part of the criminal justice system, with prison-like security. Just as immigration detention is infused with its own specific politics of migration and citizenship, however, forensic mental health institutions are shaped by psychiatric discourses, practices and norms which render these institutions distinct from prisons. This can be seen clearly in the policy language used in secure mental health; the aim is 'recovery' rather than rehabilitation, people who live in forensic services are 'patients', and on leaving are 'discharged'. Forensic institutions are also, therefore, part of the 'post-asylum geographies' (Moon, 2014) of mental health care. Generic psychiatric wards are now mostly being used for short term crisis care (Quirk, Lelliot & Seale, 2006), meaning secure mental health settings are the remaining setting in psychiatric systems in the Global North which provide long term residential care; forensic beds indeed have risen across the EU following asylum deinstitutionalisation (Priebe & Chow, 2016).

These tensions between therapy and security, or care and control are familiar to geographers of institutions, highlighted as one tension which can 'trouble' (Disney & Schieile, 2019) institutions aiming to both enclose and heal. McGeathan (2019: 2) reminds us of the "entangled nature of caring and controlling strategies and experience" in exploring therapeutic experience in prison environments, that care and control are not always distinct but entwine in complex ways in the practices of institutions. Parr & Philo (2019) draw a distinction between 'careful control', institutions mainly governed by control with some 'softening' and 'care-full control', institutions weighted more towards caring practices whilst retaining carceral elements. Where forensic institutions sit in this rubric is a little unclear. Certainly, the physical environments of forensic services are 'softer' than is typical in prison environments. Gesler, Bell, Curtis, Hubbard & Francis (2004) identified a trend in redesigning health care facilities, including secure settings, in the early twenty first century, which aimed to replace the "austere, impressive and strict" (Nord & Högström, 2017) 8) institutions of the nineteenth and twentieth century with smaller scale 'caring architecture'. The unit from which the empirical data for this article was collected is one such setting, characterised by clean, white spaces, neat individual bedrooms, curated gardens and plentiful natural light. The architectural heritage drawn upon, at least on the surface, is more from "healing architecture" (Nord & Högström, 2017) of health and the sanatorium rather than prison carcerality.

Yet still, in some ways forensic mental health settings are more 'controlling' than straightforward carceral spaces. To leave, patients must be assessed as low risk and in recovery, by both psychiatric and criminal justice professionals. Patients can overstay their original sentence, as they must pass complex risk assessments to be discharged. Risk therefore polices the border of the institution, and indeed has been argued to dominate these settings, exerting: "a powerful influence on the culture, atmosphere and everyday practices in secure services" (Barker, 2012: 28). Whilst in prison, reform or desistance are for the most part, optional, in secure settings, 'recovery' is mandatory. As well as controlling the physical liberty of patients, therefore, secure settings to a more intense degree than a traditional prison must also, as Parr and Philo (2019: 242) put it: "produce" particular and supposedly improved versions of human minds and bodies". To leave a forensic institution, a patient must demonstrate their 'improvement', through the terms set by the institution. Perhaps we can begin to see here that care - therapy, recovery, health - are less a 'softening' of control in forensic settings, and more a complication, which can involve a layering or deepening (Crewe, 2010) of control beyond the physical and into the mind and self.

1.2 Institutional mobilities

The logic of forensic services, at least of medium and low security, is one of transition and change (McGrath et al, 2021). Patients must demonstrate they have changed, in order to leave, and the institution must demonstrate patients have changed (in the UK, to the Ministry of Justice), to be allowed to discharge them. This sets up another tension in the institution, between movement and stasis. As has been amply explored in the carceral mobilities literature, carceral spaces are often conceptualised mainly as places of stasis and immobilisation; where people are held still and prevented from moving. Geographers have challenged this view, exploring the micro-mobilities (Turner & Peters, 2016) and disciplined mobilities (Moran, Piacentini, & Pallot, 2012) present in carceral systems, as well as highlighting the porous boundaries and movement within carceral spaces (Turner, 2016). Similar points have been made about contemporary psychiatric wards as 'permeable' (Quirk et al, 2006), due to the movement, both sanctioned and unsanctioned, of people, drugs, communications and relationships through the boundaries of the institution. Within forensic services, moreover, another kind of movement is embedded in the logic of the institution, a movement from one state of being to another, demonstration of which is compulsory for greater mobility in the physical sense. Institutionally, this 'movement' is operationalised and marked as progression along the 'care pathway', conceptualised as patients moving from 'ill' to 'recovered' and from 'risky' to 'safe' (Drennan & Alred, 2012).

Progression 'along' the pathway involves a changed relationship to space, as patients progress from escorted to un-escorted leave, to community visits, to highly monitored community living, known as 'staged discharge'. To use Moran, Turner & Schliehe's (2018)'s term, patients move through decreasing 'carceral circles' in their journey back to community living. Returns to the institution following a violation of some kind (drugs, offending, lapse in medication use) are not uncommon, forming a kind of 'carceral circuit' (Gill, Conlon & Moran & Burridge, 2016) into and away from the physical boundaries of the institution. Assessment and progression down the care pathway is individualised, meaning that the forensic institution varies for patients in terms of the volume or capacity (Peters & Turner, 2018) of space which is available to them at different points in the time in the service. As patients move through the service, the institution become more voluminous, increasing the capacities and affordances the space offers to patients; this can also be retracted if patients 'move back' down the pathway for any reason. To take up Cresswell's (2010) terminology of the different forms of mobility, individual patients move through the institution with varying speeds and rhythms, experiencing different frictions and setbacks, but arguably with little choice of 'route'; the pathway out of the institution is highly regulated and structured.

1.3 Modes of ordering

Attendance to questions of mobility, routes, frictions and speeds also orientates us to thinking of the institution as not static, but as a set of processes. Involved in mobility through and out of the institution are a constellation of materials – physical, social and psychological - which intersect in complex ways. Focussing on single themes, such as care, control or indeed mobility arguably limits our understanding of the ways in which these elements of institutional geographies intersect, coalesce, amplify or frustrate each other, and how they are experienced and managed by staff and patients living and working in these spaces. In this paper we therefore draw on John Law's (1994) concept of 'modes of ordering'. Law (1994: 83) characterises a mode of ordering as:

> *fairly regular patterns that may be usefully imputed for certain purposes to the recursive networks of the social. In other words they are recurring patterns embodied within, witnessed by, generated in, and reproduced as part of the ordering of human and non-human relations*

Law's concept has several benefits as a "tool for sensemaking" for this research. Firstly, Law (1994: 110) argues that any 'mode of ordering' includes the "full range of social materials", embedding the concept in a relational materialism which views spaces as being constituted through recursive, interlinked social and material processes (e.g. Massey, 1994; Lefebvre, 1991). A mode of ordering is also posited as an active process, a verb, rather than a noun. As Law (1994: 101) states:

> *There is no social order. Rather, there are endless attempts at ordering. Indeed this is where I have gone to draw my own picture of the social: the recursive but incomplete performance of an unknowable number of intertwined orderings.*

This concept therefore orientates us to consider the processes through which the unit is organised, as well as the materials, relationships, and activities through which this ordering takes place. Considering the complexities and contradictions of forensic spaces outlined above, we also agree with Nord & Högström (2017: 9) that Law's concept offers a useful framework for investigating the "complex layering" of carceral, psychiatric, coercive and therapeutic practices intertwined in forensic services.

2. Methodology

The qualitative material analysed in this article is from a project with 40 staff and patients on a medium forensic mental health unit. The study examined how experiences of distress and recovery were lived in the hospital spaces. The unit contained a mixture of acute and rehabilitation wards; the acute wards generally housed those in more extreme states of distress. There was also a ward for those diagnosed with personality disorders, and a women's ward. Alongside the wards were a therapy block, containing rooms for activities, a gym, shop and library, and the administrative block, containing staff offices. Gardens surrounded the wards. A total of 20 staff members and 20 patients took part in the research,

from a range of wards. Access was granted through senior management and following ethical approval from relevant health service and University ethics committees. Both staff and patient participants were recruited by a resident mental health professional, and consent was gained both verbally and in written form, using health service recommendations. Before patients were approached to participate, a consultant first assessed whether individuals were a) in a position to consent and b) not overly distressed at the time. Exclusion criteria included profound learning disabilities, and a sex offending history.

Patients were interviewed using a photo production method. They were asked to take photographs of the places on the ward which were meaningful to them, followed up with interviews where they were asked to explain and reflect upon the photographs. Photographic methods (Knowles & Sweetman, 2004; Prosser, 1998) have been argued to be particularly good in prompting participants to discuss the settings and context of their experiences, as visual materials are organised spatially (see, Bolton, Pole & Mizen, 2001; Gabb, 2009). The photographs were primarily understood as prompts which helped to elicit accounts of the various places in which difficulties were experienced, and hence given meaning by the participant in the context of the interview, rather than treated as data to be analysed independently (Reavey & Prosser, 2012).

Semi-structured interviews were conducted with staff members, focussing on the use and experience of space on the ward. Participants were asked to reflect on the differences between the unit under question and previous working environments, as well as reflect more generally on the space provided in the unit. The staff interviewed encompassed number of different roles, including at least one psychiatrist, social worker, psychiatric nurse, and psycho-social worker. Both staff and patient interviews were transcribed verbatim.

2.1 Analytical approach

We conducted a Thematic Analysis (Braun & Clarke, 2006), through a mixture of individual and joint analysis. Group analysis helped to ensure the analysis was grounded in the data (Creswell & Miller, 2000). Having identified key themes to pursue as further avenues of analysis, and then returned to the data to further interrogate the data, as well as seeking potential theoretical tools to help guide and develop the analysis. This paper was developed from an initial interest in the role of food, eating, and other 'domestic' activities in the data. This interest led to a consideration of the logics which were operating in the unit, organising these everyday activities. It was this focus which led to the identification of 'modes of ordering' (Law, 1994) as our primary analytic tool.

To identify our 'modes of ordering' therefore, we examined the data for the key patterns and concerns which reoccurred through the interviews in terms of how participants justified and conceptualised their work or inhabitation of the unit. We considered which concerns were prioritised by participants, and what this could help to illuminate about the most prominent modes of ordering in the life of the unit. We looked at how these modes of ordering were enacted and spatialised, considering where the different activities and relations mobilised by the different modes were taking place on (or off) the unit. Following this process, we identified two driving modes of ordering which can be seen to characterise much of the life on the unit: 'keep progressing' and 'keeping safe'.

3. Modes of ordering on the forensic unit

Throughout the data, the complexity of the relationships between care/control and mobility/stasis in the work and life of the unit were evident. These concerns were discussed as being both in tension and in concert at different times, as staff and patients negotiated the arrangement of objects, activities and spaces on the wards. Access was a recurring issue, with both staff and patients describing access to objects and space - whether cups of tea, the telephone, the garden, therapy, or community space - as a key site of negotiation, frustration and conflict between staff and patients. Understanding the staff and patients in the unit as engaged in ongoing orderings of these spaces, activities and objects, we identified 'keeping safe' and 'keep progressing' as the two key logics organising life on the unit. Involved in both of these 'modes of ordering' were the key dynamics of care/control (Parr & Philo, 2019) and stasis/movement (Turner & Peters, 2016) identified in institutional and carceral geographies. These modes of ordering both mirrored and cut across these dichotomies, as sometimes risk was managed through change and care enacted through safety. Below we explore how these fundamental tensions in the life of the unit were reconciled through reconciled through rhetorical and spatial strategies, arguing that ultimately, safety remained the central practice of the unit, with progress or change relegated to the peripheral in both spatial and rhetorical terms.

3.1 Keep progressing! Spatialising transformation and change in the forensic unit

As outlined in the introduction a key logic in forensic services, distinct from prison, is that in order to leave the institution patients must demonstrate that they have changed. 'Recovery' is the language used to evoke the change needed, which in secure services is bound up with being assessed at low enough risk to be discharged to the community (Drennan & Alred, 2012). 'Progress' through the institution was marked with an expansion of allowable spaces and objects. For instance, when comparing medium and low secure units, one psychiatrist commented that:

> *it's not quite so observed the whole time […] they are allowed more possessions that they would have in medium security. You know, you're coming into lower security […] there should be, you know, advantages to that […] they are allowed to have a phone on them as well […] non-smartphones, or dumb phones, on the ward in their bedroom*

This compares to the empty and rigid spaces described on the acute wards, where few domestic objects were allowed:

> *No, no, no, they don't have tellies in their room [on the acute ward] because of the – the kind of patients they – they have […] Maybe – maybe – maybe – maybe you might just have a radio.*

In these accounts, progress along the care pathway is enacted through filling space, loosening surveillance, and greater agency. In the low secure unit, progress towards the community is described as being tied up with a widening of activities and "more possessions"; patients' spaces become more loosely organised and filled with more personal objects.

Within this system of expanding and filling spaces, leave was a key mechanism. Staff and patients described leave as a key driver and motivator which permeated through everyday life; all behaviour on the wards could potentially affect leave privileges, particularly violence, drug taking or non-compliance with medication. The contractual quality of leave was explicitly discussed by staff:

> *The sort of conversations I have with patients is, "I'm not going to get a medal for finding some substance in your room or a sharp weapon or whatever […] rule breaking behaviour you've engaged in. I'm here as a nurse of, you know, thirty odd years exp – to help you get as well as you can and get out of here, that's my job." […] So if they're doing stuff it means you lose your leave, you don't get out of here quicker, you know, I put it back on them […] the game is for us to help you to build a life outside of hospital.*

Compliance was positioned as necessary, otherwise:

> *…they lose the lot. They've got to start all over again. So it's in their best interests really. I mean I know there's a lot of – the same as any place, they don't wanna be here. They'd rather be anywhere but here. But the only way they're gonna do that, basically, is to behave themselves really. […] behave yourself, do as you're told, take your medication like you're supposed to, then you've got a chance of getting better.*

'Progress', the ability to leave the hospital both in the present, and in the future, is hence used as an organising factor by staff to induce compliance in patients. Being well and being compliant are here positioned as equivalent, as has been long noted in psychiatric institutions (Goffman, 1961). The

decision to leave is here repositioned as a 'choice' of the patient, despite the limited choices they are given within the context of the institution (comply or stay here). Control is here positioned as a form of care (how to 'get better'), both are enjoined in the institutional logic of facilitating 'progress' through and out of the institution. The 'route' (Cresswell, 2010) of mobility out of the institution is hence heavily regulated; to enact future mobility ("get out") patients have to comply with the immobility of confinement and accept the route prescribed by the institution. A recovered future is held as an instrument of control in the present.

3.2 Performing recovery: Inscribing a changed self

One 'friction' (Cresswell, 2010) slowing progress out of the institution, therefore, could be seen to be patient non-compliance with rules, a failure to change in the required manner. Another key 'friction' were identified by both staff and patients was that progress and change needed to be visible and actively inscribed into the records of the institution. Staff positioned external forces as policing the boundary between the institution and the community, needing to be appeased before patients could be discharged:

> *I have to basically present [the patients] all the time […] MAPPA referrals, victim liaison referrals, and everybody just coming out with their own forms […] it's not internal, it's not – it doesn't come from internal, from inside the hospital is when you're actually dealing with outside agencies. […] and it's just, it's just like too cumbersome, too onerous, just completely out of the ordinary. […] I think it's to do with accountability and people just proving their own worth […] Sometimes for statistics and for, for record keeping. And the most disappointing thing is that when you've completed all the paper[work] […] you go to the meetings and they haven't read it.*

Movement into the community, is here described as being achieved through representations of patients as data - their 'dvidual' (Deleuze, 1992) rather than individual selves. The existence of a referral is presented here as more important than the actual content of the referral; what is required to navigate through this final barrier is a concrete record that procedures have been followed. The paperwork hence holds the accountability of the organisations involved, should any breach happen in the community. Internally, there was a similar emphasis on performing change and recovery. As one nurse commented:

> *[patients] see leave as the priority, whereas we would try and encourage the groups […] if you've got a patient that's particularly preoccupied with coming off section [..] I would say that at the moment you're not doing anything to justify them removing that section from you. […]*

> *you've got to build up a portfolio really, of what you're doing […] And by going to groups […] you, you're showing that you're actively making efforts to address […] those type of things. So without that (pause) they're not going – so they're not going to discharge you really because you're not giving – you're not – you're not putting any faith in them that you're ready to – to move on.*

The nurse here draws a distinction between the lived process of recovery, a personally meaningful journey taking a unique shape for each individual (Deegan, 1996), and recovery as performed, translated into an object which can be recorded by the institution. To "build up a portfolio" of recovery which demonstrates "efforts to address" their past selves, patients must demonstrate involvement in specific, sanctioned activities. This practice extended to those patients who had been recalled:

> *because you have to do the groups.[…] You have, you have to do them or basically they won't let you out. But it's a bit silly, because I've done them about five times already. […] Each one. So – but it is re-educating you, retelling you they'll let you out and then that's it.*

Achieving 'progress', therefore was also positioned as needing to actively perform recovery, through repeating specific set tasks and groups, performing preparation for obedience in the community. Visible in the patients' photographs and narratives were ways in which they acted to perform a recovered and reformed self, actively inscribe their recovery into the spaces of the institution.

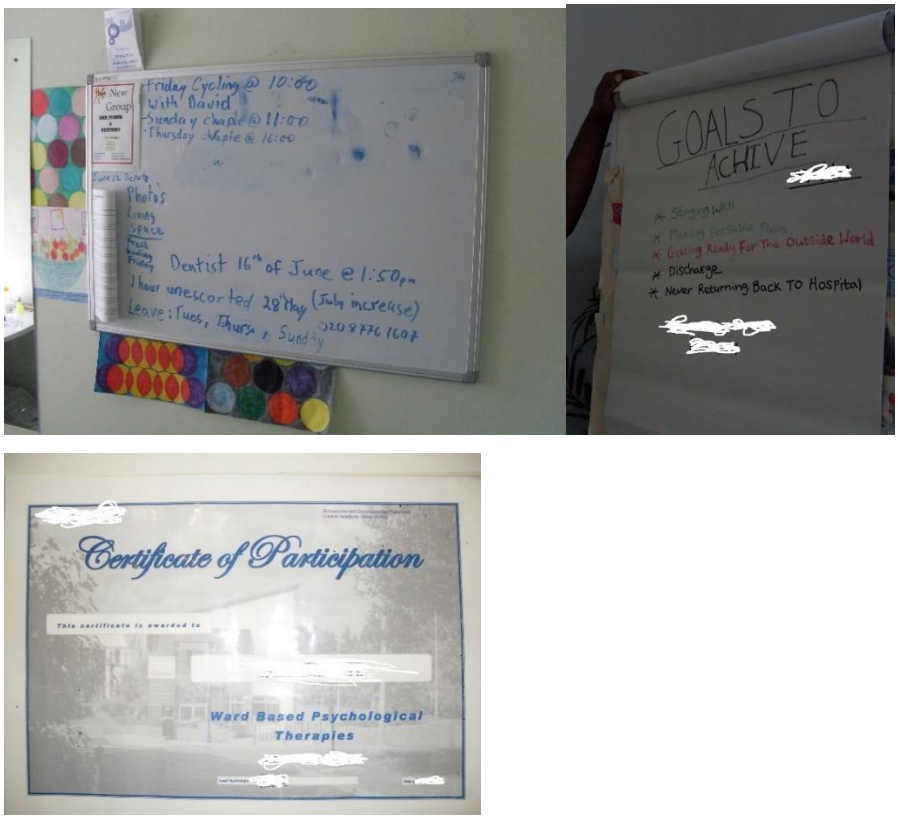

Figure 2: Patient photographs of certificates and goals

On the use of the whiteboard, the patient commented:

> *I've started using it in the last month. […] we were discussing it in one of the – in one of the groups […] So it's something that I've been starting to use in the last month now.[..] At home then I would be using a diary and using Post-Its to keep myself scheduled properly.*

In these examples we can see patients sharing various ways in which they inscribed their participation in their 'pathway' out of the institution into the everyday space of the unit. Participation certificates from the groups required to demonstrate readiness to move through the institution were posted on the walls of one participants' bedroom. Other participants shared their scheduling and goal setting, again inscribing in the space of their bedrooms their internalisation of the 'skills' learnt in the groups on the wards, seeking to demonstrate their willingness to imbibe the norms of the institution and perform themselves as recovered. Duff (2011; 2012) argues that to move through a process of recovery, a whole constellation of materials (social, personal, spatial) may be drawn upon; he argues an 'enabling place' is one which provides multitudinous materials open for the creativity of the person in recovery to utilise. We can see here that patients are offered a limited set of materials - groups,

whiteboard, certificates - to draw upon and demonstrate their recovery. These activities have heightened significance as the 'route' through and out of the institution, with inadequate performances of recovery being key 'frictions' which would slow or prevent mobility into the community. Staff and patients here are both engaged in this game of performing recovery - patients to the institution, and the institution to the community. Control and care are entwined, not opposed, towards the same end of 'progress'.

3.3 Keeping safe: Rigid anticipatory geographies

Perhaps a greater 'friction' in play in the forensic unit, however, is the other mode of ordering we have identified: 'keeping safe'. Safety in the forensic unit ordered disparate activities, materials and people. Alongside the nakedly carceral features of the space (locks, fences), the organisational preoccupation with keeping safe we here argue acted to slow down relations on the unit, resulting in experiences of being stuck, and creating empty, lifeless, and limited spaces. The mode of ordering 'keeping safe' we here argue can therefore be seen to diminish the capacities (Peters & Turner, 2018) and affordances offered by the spaces of the unit, frustrating the possibility of progressing as the logic of the institution also required.

A concern with safety as a driver of the organisation of space, relationships and activities in the unit was firstly evident in the visibly carceral features of the unit's architecture. Locks, fences and doors were all commented upon by participants as marking the space as custodial. Several patients, for instance, included photographs of locks and fences, such as the one in the opening section. Patients highlighted the ways in which security features of the architecture underlined their lack of freedom and their status as incarcerated people. As one patient commented:

> *P: So, with the high fences and all that, it's sort of like a prison. Well, it's worse than prison. The fences are higher and there's more doors and—*
>
> *I: So how does that make you feel, that you kind of go outside and—?*
>
> *P: Stuck.*

The architecture of confinement - fences, doors, locks - is here described as inculcating feelings of being "stuck", of stasis and a lack of agency. The carefully curated garden here is presented as not being able to counteract the feeling of incarceration, being "worse than prison". As another patient commented, no matter what the material environment of the unit was like, "you're still locked up". While the garden is clearly provided here with the intention of being a form of 'caring architecture' (Nord & Högström, 2017), for this participant, any sense of respite or outside space is blocked by the

literal and symbolic presence of the prison-like fence, a reminder of their restricted status. The garden here can be seen as deepening, not softening, the carcerality of the space.

The mode of ordering 'keeping safe' was also evidence in the ordering of objects, relationships and activities on the wards, compounding the immobilising qualities of the architecture. Patients and staff described the rules on the acute wards as being most rigid, with strict meal- times and regulated activities. As one patient commented:

> *And I say to her, "Okay, can I have a cup of tea?" They will say, "No, it's not time." You know, so if you're ever distressed, say you're openly distressed, yeah, and you are trying to explain yourself and nobody knows what you're talking about, and all you want is a cup to tea to, to go over and try and collect your thoughts*

This account describes the acute ward, where patients are at their most distressed, as being both an empty and rigid space 'Keeping safe' on the acute ward was described as a process of clearing the space of potential risks, achieved through emptying the space of objects and activities. Curtis et al (2013) describe risk-governed space in a forensic unit as 'smooth', due to a focus on limiting patients' ability to mobilise the space for 'risky' purposes - such as self-injury, escape or violence. In addition to smoothing the material space of the unit, we can see here that 'keeping safe' leads to an emptying of the space of objects and activities, further limiting and reducing the possibilities for action for patients, reducing the 'capacity' of the space (Peters & Turner, 2018).

Risk here can be seen to shape the 'anticipatory geographies (Anderson, 2010) of the unit; some 'emptying' was pre-emptive with strict limitations were placed on the objects allowed into the space, in anticipation of potential risk. Others were removed after specific incidents. A reason for acute patients being unable to make their own tea, as described above, was due to a kettle being used as a weapon in the past. The institutional memory of water thrown from a kettle, here can be seen to reach into the present ordering of the space, limiting the activities and relations of the current inhabitants. This tendency could be seen most starkly in the seclusion room, the place for patients categorised as at their most risky:

> *It's blank. It's got a bed and a supervised confinement clothing, shorts or bed – bed linen, yeah. [..] I think certain factors are being taken into consideration, in terms of, um, managing risks, managing, um, for example, maybe suicidal thoughts, because the patient is going through so many things. So the room is left as bare as – as possible.*

Safe here means empty, "blank", removing the possibility of the patient being able to move, impact upon or mobilise the materials of their environment. The seclusion room can be seen as the opposite

of an enabling place (Duff, 2011; 2012), especially as blank spaces can increase psychotic symptoms (Grassian & Friedman, 1986) and psychotic crisis is often accompanied with an urge for movement and seeking action (McGrath & Reavey, 2016). In these well-funded services (Chow & Priebe, 2016), the logic for emptying the space in this way is to 'keep safe' by reducing the possibility of acting on the environment to harm self or others.

This tendency to operationalise 'keeping safe' as absence, simplicity and rigidity were in evidence in other practices in the unit. A senior nurse, for instance, commented on a change of policy in the delivery of meals on the unit. Meal- times, where patients gather together to eat were described as a hotspot for conflict and "the most difficult time of the day" on the wards. In response to increased arguments, the senior nurse commented:

> *we're not gonna have all these choices anymore, because having these choices creates arguments. Not because – people might order shepherd's pie and then when it arrives or they look at it, they go oh no I don't like to look of that, no actually, I want to have the cheese salad, um, – you think – because it's hot today. And you think well, we don't have that but, you know, you've ordered this, now you have to have this. […] So they've decided they're just going to just have one dish of the day, and everybody will eat the same foods […] So, we hope that that would completely change the atmosphere at meal time because there will be no longer discussion about what people are going to eat*

Here the response to conflict and frustration around meal- times is to strip away choice and reduce interaction. Patients commented that meal times were already devoid of conversation or sociability, saying that "everyone just eats" while staff "supervise"; food arrived through a "hatch" in the wall and was described as "kind of bland, there's no taste to it" and that "you just get fed up with the same thing". One of the therapeutic staff on the unit similarly commented:

> *Yeah. I mean I think the problem with food here is that it's quite repetitive […] it repeats either every two weeks […] when they get, you know, the same fish and chips. […] I know that some people complain and they would say, "Oh yeah. You know, because it's always chicken or it's always that" so maybe it's down to the fact that it's actually (pause) repeating*

Conflict and frustration circulating around a repetitive, bland selection of food are therefore responded to by further reducing choice and variety. Here we can see what Barker (2012: 28) called a "culture of control and anxiety of lack of control" in forensic services, leading to clinicians seeking certainty above generative possibility. 'Keeping safe', in terms of negating and reducing conflict on the ward, is here operationalised as reduction of possibility, variety or activity, as a further dampening

of interaction. In the same way as the acute wards and seclusion rooms are emptied of objects, their material environments made rigid and smooth, so the daily activity of eating together is here also emptied out, reduced to its bare minimum.

'Keeping safe' can be seen as a mode of ordering which tends towards rigidity and immobility. To be certain of safety, objects are removed, while activities and relations are limited. Carceral architecture slows down relations and movement within the units and between the unit and the outside world, whilst the practices of risk management empty and stultify spaces. To be completely 'safe' within the logic of the unit is to be still, alone, in a blank room incapable of action, relation or movement.

3.4 Reconciling 'keeping safe' and 'keep progressing'

'Keep progressing' and 'keeping safe' thus operate as modes of ordering which pull in opposite directions. 'Keep safe', we argue tends towards empty, stultified and static spaces and 'keep progressing' which instead requires filling, enriching, and ingraining spaces. These two imperatives produce obvious tensions within the life of the unit, which we argue were resolved through various rhetorical and spatial strategies. The first strategy used to reconcile these contradictory logics was in representing them as not opposed, but as aligned. This was manifested in representing safety practices as being the choice and interest primarily of the patients:

> *I mean, when we came over here, we worked extensively with the patients to review the […] what should be allowed and what shouldn't. So it was very much a collaborative agreement on what the actual possessions should be and shouldn't be. They're all into safety. They want to be living in a safe place. They want to feel protected. […] it's just as important to them as it is to us.*

As well as being more broadly in the interest of the patients:

> *we have to be escape proof. I'm very interested in the space that we have here and […] its perimeters and we make sure that we don't have an escape cos it would have a massive impact on the service and the patients*

In both of these accounts, safety is positioned as a concern of the patients. Firstly, demonstrating an interest in safety is presented as being part of how patients demonstrate their ability to move on, their recovery. In the second quote, the psychiatrist depicts the fences as protecting, not the community, but the service and the patients. In both examples, safety is positioned as a concern which facilitates movement through and away from the service, rather than impedes it. This is achieved through repositioning safety as primarily a concern of the patients, rather than it being an expression of control

and containment. A related strategy was used by a nurse discussing patients' initial reactions to the building:

> *When we bring our patients here, sometimes, um, they're surprised to see the fences […] Because they're coming from a place where the fences are exactly like this, so when they see the fences like this, they talk to some of us nurses and say, "Oh well, we thought we were coming to medium secure and it'd be less custodial and less threatening." Then […] when they start their programme here, they see that it's more therapeutic in other ways […] So, they have leave, we're more relaxed with them, we […] collaborate with them on so many issues and […] they do know that yes it's different from where they came from.*

In this account, the nurse acknowledges the custodial architecture of the unit, and its surface similarity to the 'pure containment' (Moran et al, 2018) of prison. In contrast to the previous strategy of positioning safety as a route to movement, here the 'therapeutic' elements of the unit are situated in the non-material elements of the space; in relationships, leave, and collaboration. These relational aspects of life on the unit are positioned as being ameliorative to the carceral architecture, as softening the space and making life in the unit less rigid than one conjured by prison fences.

As we have argued above, there is merit in the idea that the forensic unit is governed in ways which differ from the 'pure containment' of prison. The relative loosening of relations and movement referred to by the nurse here as 'therapeutic' can be understood as instances of the 'keep progressing' mode of ordering. We argue here, however, that the modes of ordering of safety and movement have a more fine-grained spatial distinction than simply material space vs relational space. Instead, these modes of ordering tended towards domination in different spaces in the unit, with safety being more central, and movement more peripheral.

Whilst each ward operated differentiated regimes, the rules of the ward tended to be governed by the patient with the least freedom:

> *Over a period of one month, they've smashed four of their tellies on [acute ward]. So if – if you are well on that ward, how are you expected to cope? There are some who can't do with a telly because their mind is telling them that their telly has been abusive to them. So you keep smashing the telly. And someone who wants to watch the World Cup and he can't have a telly in his room.*

In this account we can see that on the acute ward the rule of 'no TVs in the bedroom' is upheld even if people are 'well'. The rules of the ward are therefore governed by those who are least 'well', or stable. Ward environments have to cater to the 'risk' of everyone living in the space, which means

catering to the most 'risky' person there, requiring the emptiest space. Most vulnerable to this process, of course are the communal spaces and shared communal activities (meal- times, medication rounds, pool, and in this example - TV). 'Keeping safe' thus dominates in communal spaces and underpins the spatial rules of each ward.

Many of the spaces, objects and activities mobilised through the mode of ordering 'keep progressing', on the other hand, were located off the wards or limited in access, either in the 'therapy block' or rooms accessed from the wards but usually locked. One example of this was the 'therapy kitchen' which was located on each ward but access to which was tightly controlled:

> *I: Yeah. So there's no way for them to cook food or prepare their own?*
>
> *P: That one has to be arranged with their OT. […] and you get to do that once a week. However, there's six days left, you know.*

This was despite patients often commenting on the enriching and enlivening quality of using the kitchen to cook for themselves and other patients:

> *P: And, um, so I budget the purchasing of the of the food that I that I cook with, so it's a bit of satisfaction. And I also, a few times I cook for other people as well. [...]I've had a few who've shared it a little bit and, um, yeah, so it's just a little bit of time coming together and something that's not possible*
>
> *I: So what's that like when you get the opportunity to share a meal with—*
>
> *P: Oh, it's good. It's good. It's nice. It's a little bit of satisfaction when you get the thumbs up (laughs). […] Yeah, that's good. […] We try with what limited stuff that we have.*

In these examples we can see how the enriching experience of using the kitchen, cooking for staff and other patients, is strictly limited, peripheral to the life of the ward both spatially and temporally. Other patients similarly discussed engaging in artistic activity, which was located either in their bedroom or in the therapy block art studio. There were limited possibilities, however, for the products of creativity to permeate the shared space of the unit where again communal, not individual, safety concerns were in operation. Patients were left instead, with only limited materials such as the whiteboard - to demonstrate their 'progress' to the institution and

Overall, however, we argue that the central mode of ordering which organises life in the unit is to 'keep safe', tending towards stultification and stasis. The activities and relations mobilised to 'keep progressing' tended to be more peripheral, spatially and temporally, in the life of the unit. A spatial hierarchy thus exists which relegates 'keep progressing' to the side-lines, restricting patients' access

to the very materials (social, material, relational) which they need to perform and inscribe their recovery.

4. Conclusions

Forensic psychiatric services are caught in a difficult position, being asked to achieve contradictory aims. There are genuine risks of violence and harm; as Drennan & Alred (2012) point out, whilst violence and mental distress are not always related, violence is often a part of the distress and offending history of those detained in secure psychiatric settings. The criminal justice system also polices the boundaries of the institution, limiting possibilities for action and movement. Yet in our analysis it is clear that these genuine concerns and constraints can balloon to overwhelm and overpower the space of the forensic unit. As Moore (1995: 3) argued, in forensic services: "suspicions harden into theories, anecdotes ossify as rules and prejudices become accepted as indicators which guide practice and reduce anxiety'". This rush to avoid anxiety all too often tends towards seeking certainty (Barker, 2012), which in terms of the space, we have argued, leads to immobilised, stultified and empty spaces, which in turn are anathema to recovery or rehabilitation, as these are inherently dynamic processes, necessitating change.

We have argued here that whilst change and progress are a central concern and logic of the institution, both rhetorically and spatially change or progress is always secondary to safety. A key implication here is that the forensic units are not being successfully harnessed as a 'enabling place' (Duff, 2011; 2012), even though elements of the space may look more like a 'therapeutic landscape' (Gesler, 1992) than prison, such as the garden in the opening paragraph. Creative, enriching activities are side-lined and individualised, pushed out of communal spaces and stripped out of daily activities by the overwhelming attendance to 'keeping safe'. A contrasting approach can be found in the therapeutic community movement, a central tenet of which is that patients have joint responsibility for daily tasks such as cleaning, cooking and maintenance (Warner, 2000). Responsibility for daily tasks is shared as part of the mission of therapeutic community approaches to break down the us/them power dynamics and a passive patient (Repper & Perkins, 2003). The entirety of the space is thus harnessed, rather than recovery or therapy being a peripheral concern. Whilst the whole space is harnessed to enact the care pathway, meaning that patients' spaces become less empty and looser as they move towards discharge, this process is individualised and limited by the way risk is tied to 'smoothing' space (Curtis et al, 2013). The requirement placed on both patients and staff to make recovery visible - to the institution and to external gatekeepers - is constantly frustrated by the stripping of the spaces of the institution of potentially enriching or meaningful objects, activities or interactions.

Taking the dynamic, processual approach encouraged by Law's (1994) 'modes of ordering', has helped to illuminate the complexity of how established institutional concepts such as care/control (Parr & Philo, 2019) or mobility/stasis (Turner & Peters, 2016) are enacted, frustrated and moulded in the everyday practices of the wards. We have here added to the institutional mobility literature through exploring the 'routes' and 'frictions' offered by the care pathway, extending these concepts to encompass the imagined mobilities delineated by policy as well as the mutating physical micro mobilities mapped out as patients move towards discharge. In this institution which requires transformation of the self, mobility comprises both of these. This paper therefore adds to the emerging literature on the capacity (Turner & Peters, 2018) and depth (Crewe, 2011) of institutional spaces, to which can be added the sense of expanding capacity and affordance of the spaces of the institution as patients move through staged discharge. The forensic example makes clear that these capacities are personal as well as physical, and the expansion and contraction of the spatial capacities each patient has access to is construed as both care and control, rather than a movement from one to the other. Indeed, throughout this paper we have argued that rather than being in opposition or defined in tension, in practice care and control are often enjoined together. Although sometimes care can be a 'softening' (Parr & Philo, 2019) of control, the therapeutic practices of the forensic institution, sidelined as they are, often instead act to deepen or extend control. Shifting the emphasis to the dynamic processual logics of the institution, understood as mobilising material, social and psychological elements together, can help to unpick and illuminate the complexities and contradictions inherent in institutional geographies, unpacking these dichotomies as being mobilised for different, sometimes contradictory aims.

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