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Stasis disguised as motion: Waiting, endurance and the camouflaging of austerity in mental health services

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This paper develops an account of the camouflaging of austerity as an institutional strategy. In doing so it brings together and advances geographical literatures on mental health, waiting, and austerity. Where geographers have tended to focus on moments when austerity surfaces in everyday life, this paper addresses those moments where austerity is made to recede. Presenting evidence from interviews with mental health service users/survivors, I argue that stasis is a central feature of encounters with the austere state. Such periods of durative waiting can make austerity apparent, so institutions are incentivised to camouflage them, in order to legitimate their claims of providing care. I advance the concept of the "holding pattern" to capture the mobile cycles of waiting that service users/survivors endure, arguing that these circulations inculcate cruelly optimistic affects by exploiting the immanent potentiality of waiting. These affects engender a belief that the time of care and of progress is imminent. For those held within it, the holding pattern is experienced as a form of stasis disguised as motion. The paper then analyses how people endure this travel without a destination. I demonstrate that, like the holding pattern, these practices of endurance make use of potentiality. Some cast themselves as responsibilised neoliberal subjects, to blame for the lack of meaningful care they receive; others reclaim the potentiality that fuels the holding pattern, engaging in ongoing practices that are sustaining despite their seeming uneventfulness. The paper highlights the centrality of austerity to contemporary mental health geographies; develops a critical account of the politics of stasis and waiting; and argues that the camouflaging of austerity will prove increasingly important to the legitimation of beleaguered "universalist" social services. I conclude with some reflections on the potentiality of a grinding politics of resistance to austerity.

KEYWORDS
austerity, mental health, mobility, qualitative interviews, United Kingdom, waiting

Content warning: sexual violence, suicide, suicidal ideation

1 | INTRODUCTION

In this paper I develop an account of the camouflaging of austerity as an institutional strategy. Drawing on the experiences of people attempting to access mental health services in the UK, I argue that stasis is a central feature of everyday encounters with the austere state, and that mobile waiting is deployed by services as the solution. In doing this I bring together and advance geographical literatures on austerity, mental health, and waiting. Like many other geographers of "everyday austerity" (Hall, 2019b, p. 769), I am interested in impacts of state deficit-reduction that are quotidian, embodied, and affective (Hall, 2017, 2019a; Hitchen, 2019; Raynor, 2017; Stenning, 2020; Strong, 2020). While recognising that austerity is often an "absent-presence" in daily life (Hitchen & Raynor, 2020, p. 186), this body of research has often foregrounded those moments when austerity surfaces (Raynor, 2017) and the consequences of fiscal retrenchment settle into bodies as a structure of feeling (Hitchen, 2019). I argue for the importance of the opposite: those moments when austerity recedes, dissipates, or is veiled. The legitimation of austerity as a political project relies on the disguising and denial of its many violences (Tyler, 2020).

Stasis – understood as periods of durative waiting – threatens to expose austerity. The affects that emerge within stasis – feelings of slowness, stuckness, and stillness – can lead to a sense of being out of time with the progressive thrust of capitalist modernity (Baraitser, 2017). This undermines claims made by its proponents that austerity increases state efficacy (Hitchen & Raynor, 2020). In the remainder of this paper, I contend that as austerity makes stasis more prevalent and more visible in encounters with state services, these bureaucracies respond with strategies that work to disguise stasis. I focus on one strategy in particular: the deployment of mobility. When people are made mobile across multiple services and spaces, this can enliven the dead time of stasis with promises of an imminent return to progress. Borrowing a term from Tom, one of the central figures in this paper, I described this as a "holding pattern."[1] This mobility exploits the potentiality of waiting, its inherent capacity to become something otherwise (Bissell, 2007). Yet this strategy is only ever partially successful: for some, the delayed hope that it inculcates comes to be experienced as cruel optimism (Berlant, 2011). I conclude by analysing the consequences when mobility fails to seduce. I examine the daily practices through which people endure prolonged periods of waiting when a return to progress doesn't feel close at hand; these practices also exploit the immanent potentiality of waiting. I argue that these practices are best understood as quasi-eventful (Povinelli, 2011) micro-political projects that nonetheless offer emergent possibilities for resisting austerity (see also Wilkinson & Ortega-Alcázar, 2019).

Throughout, my attention is on mental health services precisely because geographers have paid relatively little attention to the impacts of austerity on these services (Lowe & DeVerteuil, 2020a). By focusing on mobility I contribute to a strain of theory that has been central to mental health geography since its inception as a subfield. Building on a centuries-old association (Cresswell, 2011; Philo, 2004), geographers began to theorise the relationships between madness, deviance, and highly mobile people following the deinstitutionalisations of the mid-20th century. This work drew attention to processes that produced "service-dependent ghettoes" (Dear & Wolch, 1987): clusters of community psychiatric services and discharged patients in inner cities across North America and the UK (Wolch & Philo, 2000). This was underpinned by a restructuring of public services that sought to reduce dependence on the welfare state while introducing greater private provision (Joseph & Kearns, 1996). Geographers examined the mobility of former inpatients, cataloguing both their "drift" across the inner city (DeVerteuil et al., 2007, p. 280) and their immobilisation within an "asylum without walls" (Wolpert et al., 1975, p. 25). Later, researchers such as Knowles (2000) and, most significantly, Parr (1997, 2000, 2008) described the everyday geographies of former inpatients, tracing these highly mobile individuals from burger bars to public squares as they navigated the non-institutional spaces of the inner city. This work often emphasised the agency of the "mad" person, who made choices about where and when they moved: a necessary corrective to depictions of psychiatric patients as lacking any rational capacity. However, these perambulations were also bounded by factors including a lack of resources, hostility from locals, and vigorous policing (Knowles, 2000; Parr, 1997).

While this literature attends to relatively self-directed mobilities (albeit within limits), the holding pattern is made up of comparatively involuntary mobilities within and across the "complex decentralized networks of services" that comprise post-asylum landscapes of mental health care in the Global North (Högström, 2018, p. 318). These mobilities are similar to but distinct from the institutional "cycling" described by earlier geographers of deinstitutionalisation (DeVerteuil, 2003, p. 362), which was characterised by unrelated institutions (DeVerteuil, 2003) and a lack of bureaucratic oversight (Knowles, 2000); in contrast, the holding pattern is more regulated inasmuch as institutions organise formal transfers of care. Like all mobilities, the holding pattern emerges from relations of power and force (Cresswell, 2010; see also Massey, 1994), reflecting the relative powerlessness of service users/survivors and with potentially deleterious effects on mental health (Lowe &

DeVerteuil, 2020a, 2020b). Under strain from austerity (O'Hara, 2017) following decades of underfunding (Parsonage, 2005), services are incentivised to discharge their patients; yet they remain responsible for their patients' future behaviour and the management of risks they may present to themselves or others in the community (Moon, 2000; Rose, 1996). Consequently, caring institutions can become oriented towards control (Disney & Schliehe, 2019), attempting to transfer responsibility for troubling cases to other institutions. Tom's description of these transfers as a holding pattern references the circuitous routes flown by planes as they await clearance to land. This image captures the sense of movement without ultimate direction, the idea of a destination that may never be reached, the feeling of inertia – of stasis disguised as motion.

2 | AUSTERITY, RESPONSIBILISATION, AND MENTAL HEALTH SERVICES

The UK's Labour government responded to the global recession of 2008 with bank bailouts and emergency stimulus measures; consequently, "the private sector financial crisis became a sovereign debt crisis" (Gray & Barford, 2018, p. 542). Conservative politicians and publications blamed the ballooning deficit on Labour's profligacy, arguing that they had "maxed out our nation's credit card" (ConservativeHome, 2008, n.p.). The Coalition government came to power in 2010 promising to curb state expenditure, in order to reduce the deficit to zero (e.g., Osborne, 2010); opinion polling showed that most of the public viewed the cuts as a necessity, with the blame falling on Labour (YouGov, 2015). Subsequently, departmental spending was reduced by £41.3 billion in real terms between 2009–2010 and 2018–2019, around 10% of the total (Emmerson et al., 2019).

Austerity is a fiscal strategy under which sovereign debts are used to justify cuts to public spending (Hall, 2019a). It is therefore only the latest iteration of a longer-term "roll-back neoliberalism" (Peck & Tickell, 2002, p. 388) aiming to shrink the state. This has worsened existing raced, gendered, class, and spatial inequalities (Bassel & Emejulu, 2018; Durbin et al., 2017; Gray & Barford, 2018; Greer Murphy, 2017; Wilkinson & Ortega-Alcázar, 2019). Yet austerity is not only this fiscal project (Hitchen, 2019). A "collective national fantasy" of "virtuous" belt-tightening (Wilkinson & Ortega-Alcázar, 2019, p. 156) is integral to austerity; so too are the affective atmospheres through which austerity becomes felt between bodies (Hitchen, 2019). It is through this diffuse mesh of social, cultural, and economic forces (Hitchen & Raynor, 2020) that austerity becomes a mental health problem. Cutbacks to public finances reduce access to services and spaces with the potential to protect mental wellbeing (Shaw, 2019). Reductions in benefits and the introduction of a more punitive sanctioning system (Mattheys, 2015) combine with public narratives of virtue and vice that stigmatise those who rely on state welfare (Tyler, 2020). This further impoverishes those whose mental health leaves them unable to work (Mattheys, 2015). Austerity therefore strikes a double blow against mental health. It contributes to distress through poverty, financial insecurity, and unemployment resulting from service cutbacks (Barr et al., 2015; Mattheys et al., 2017), and then slashes the social safety net away from those who have come to rely on it (Mattheys, 2015).

Simultaneously, austerity undermines the services designed to ameliorate mental distress. Mental health provision in the UK has long been described as an underfunded "Cinderella service" (Parsonage, 2005, p. 72), doing a considerable amount of mopping up for little money. While demand for mental health services has soared over the past decade (NHS Digital, 2018), under austerity the budgets available to these services have been restricted. Between 2009/2010 and 2018/2019, local authorities in England significantly reduced their expenditure on social care, including mental health services. Per capita expenditure fell 9% in real terms; in the most deprived areas the cut was deeper, at 17% (Phillips & Simpson, 2019). Within the NHS, 62% of specialist Mental Health Trusts had a lower income in 2016/2017 than 2011/2012 (Royal College of Psychiatrists, 2018); budget increases elsewhere in the NHS have greatly outstripped those received by these Trusts (Gilburt, 2018). This is despite Mental Health Trusts employing the vast majority of psychiatrists in the NHS (Royal College of Psychiatrists, 2018). While NHS spending on mental health has risen around 3% each year since 2015/2016 (NHS England, 2020), there is a lack of data allowing the comparison of longer-term trends or showing how much of this funding is reaching frontline services.

Concurrently, a broader transformation of the geography of community care provision is taking place, under the auspices of a personalisation agenda that foregrounds personal choice in social care (Power et al., 2013). In mental health services, personalisation is often articulated through the language of "recovery," which emphasises the agency of individuals to determine a meaningful and satisfying life in the face of illness (Carr, 2012). On this basis, "semi-institutional" day centres and drop-in services that were opened in the aftermath of deinstitutionalisation (Parr, 2000, p. 232, 2008) have faced a backlash. Facing accusations that they are homogenising and institutionalising for the people who use them (Needham, 2014), day centres have been closed in considerable numbers since the 2000s (Needham, 2012). They are often replaced with personal budgets that allow services users/survivors to purchase individualised support in order to participate in "everyday" community spaces (Power & Bartlett, 2018, p. 338). In mental health services, NHS Recovery Colleges have been

rolled out, delivering time-limited courses on life skills and self-management of mental illness (Perkins et al., 2012). This transforms the space-time of service provision: there is a shift away from the longer-term, open-ended engagements of the drop-in centre (McGrath & Reavey, 2016) towards a "post-service landscape" consisting of time-limited, individualised provision "in the community" (Power & Bartlett, 2018, p. 338). First-hand encounters with mental health professionals tend to be scarce and brief, with most surveillance, regulation, and management happening from a distance (McGrath & Reavey, 2016).

The ideology of recovery underpinning these changes "began as a liberatory discourse" but was then "instrumentalised and mainstreamed" until it aligned with neoliberal values (Rose, 2014, p. 338). While being framed as a progressive remodelling of services in order to better empower their users, in practice recovery discourse masks coercive practices and service closures (Recovery in the Bin, 2016) by recasting mental health as a personal rather than a social problem, transferring responsibility from the state to the unwell individual (McWade, 2016). This individual "responsibilisation," in which service users are blamed (or blame themselves) for shortfalls in their care, is an integral part of neoliberal approaches to care service provision (Teghtsoonian, 2009). Consequently, recovery can work in concert with austerity, furthering neoliberal efforts to roll back the state by shifting from expensive, permanent sites of care towards transient, time-limited engagements in extant community spaces. This is, as Dear and Wolch (1987) first identified, social progressivism operating in alliance with fiscal conservatism.

Recovery discourse tends to elide the state of being recovered with a return to paid employment (Rose, 2014), idealising the transformation of dependent service users into self- (and market-) reliant economic agents. As Laws (2013) argues, this reductive schema paints service users/survivors as inactive and workless, neglecting both the "magical work" involved in states of delusion and obsession (Laws, 2013, p. 346) and the "recovery work" bound up in living with mental distress (Laws, 2013, p. 350). Furthermore, many service users/survivors are also excluded from this ideal: for instance, those whose agency takes them in directions incompatible with wage labour (Rose, 2014), and those who remain stubbornly "unrecovered" (Recovery in the Bin, 2016, n.p.). It is these people who are most likely to prove troublesome (Philo & Parr, 2019) to recovery-oriented services, and thus to find themselves circulated between services across a fraying "patchwork of provision" (Milligan, 2015, p. 1566) under austerity. If frontline bureaucrats have long been incentivised to delay access to services in order to preserve resources (see Lipsky, 1980), what is particular about these circulations is their capacity to alleviate the dead time of waiting, camouflaging the harmful consequences of austerity.

3 | GEOGRAPHIES OF WAITING

Waiting has been an indicator of care quality since the creation of the NHS (Baraitser & Brook, 2021), with NHS managers reporting increased waiting times for mental health services in recent years as a result of financial pressures (Anandaciva et al., 2018). Where these debates utilise a crudely quantitative conceptualisation of waiting, a growing geographical literature has catalogued the complex tangles of temporality and affect that comprise any period of waiting. From this perspective, waiting is not simply slowness, stillness or stasis, but an "incipient rich duration" (Bissell, 2007, p. 295) that always retains "the potential to be otherwise, [and] the possibility of rupture" (2007, p. 279).

When waiting becomes chronic, this "potential to be otherwise" can prove torturous. As chronic waiting – that which fills months, years, or even whole lifetimes – becomes increasingly central to the lives of marginalised people (Jeffrey, 2008), geographers have described the act of waiting for groups of people, including underemployed men (Jeffrey, 2010), migrants (Brun, 2015; Conlon, 2011; Zhang, 2018) and non-migrants (Gray, 2011), displaced peoples (Hyndman & Giles, 2011), asylum seekers (Griffiths, 2014; O'Reilly, 2018; Seitz, 2017), and, most pertinently, deinstitutionalised inpatients (Knowles, 2000). For the (ex-)psychiatric patients Knowles encounters, poverty can lead to long periods of listless boredom in the home (2000, p. 48). But waiting also actively reworks "the grammar of urban space" (Knowles, 2000, p. 29). When individuals shelter in mall stairways (2000, p. 86) or panhandle on public streets (2000, p. 94) their waiting disrupts and reshapes normative mobilities. They are not empty passages of passivity, but active strategies to secure vital resources for survival.

Together these accounts draw attention to the richness of waiting that Bissell identifies. In his account, waiting is a "variegated affective complex" (2007, p. 279) that simultaneously activates and deadens our relations to the world. In this context, affects – understood as felt intensities that emerge between bodies, objects, spaces, and forces (Duff, 2016) – can proliferate as we orient towards the possibility of change (Bissell, 2007). But they can also deaden, as when boredom suppresses the vitality of affecting encounters (Anderson, 2004; Bissell, 2007) or where affective excess is taken up by diminishing and destructive relations (Anderson, 2006).

Affects are always temporal as well as spatial (Hitchen, 2019), and the temporalities of chronic waiting are often "dull or obdurate," involving practices that are "arduous, boring, and mundane, or simply unbearable" (Baraitser, 2017, p. 1). "[A]nachronistic" time gives rise to affects that make one feel "slowed, stilled or stuck" (Baraitser, 2017, p. 6), and enduring these is enervating. In such conditions, the future – as an abstract body of progressive time – seems held at a distance from the forth-coming, a temporality comprising the immediate consequences of routinised, repetitive actions (Jeffrey, 2008); consequently there is a "dual uncertainty of time" (Griffiths, 2014, p. 1991). While a person may hope desperately for an otherwise that brings relief from the unforgiving anticipation of waiting, that otherwise may well consist of further precarity, violence, and dispossession (Griffiths, 2014). Within these conditions, the texture of time can change wildly. Time can be experienced as dearth and surplus, simultaneously (Seitz, 2017). It can feel suspended, limbo-like, and incapable of progressing towards a future; then it can suddenly lurch into a frenzy of frenetic developments (Jeffrey, 2008).

As the work of Knowles (2000) demonstrates, chronic waiting is intimately connected to uneven distributions of (im)mobility (Conlon, 2011), which are themselves structured by power geometries (Bélanger & Silvey, 2019). In the words of Massey:

> This point concerns not merely the issue of who moves and who doesn't, although that is an important element of it; it is also about power in relation to the flows and the movement. Different social groups have distinct relationships to this … differentiated mobility: some people are more in charge of it than others; some initiate flows and movement, others don't; some are more on the receiving-end of it than others; some are effectively imprisoned by it. (1994, p. 149)

The distinction here is not between those who are mobile and do not wait, and those who are immobile, who must – after all, waiting is an intrinsic part of any form of transit (Bissell, 2007), while all (im)mobilities are relational (Cresswell, 2010; Lowe & DeVerteuil, 2020a). Rather, it is that some possess more power to initiate and determine their movements, and have greater control over when, how, and where they wait. As Massey observes, mobility can still feel like imprisonment; it is entirely possible to be circulated in a chronic pattern of "waiting-in-motion" (Lagji, 2019) when mobility is out of one's control. At the same time, if waiting is intrinsic to movement, then so is a destination. Mobility offers the hope of an end to waiting, an arrival, and a return to progressive, modernist time (Glennie & Thrift, 2009). This may well prove to be "cruel optimism", "a relation of attachment to compromised conditions of possibility" (Berlant, 2011, p. 24). In this context, cruel optimism is the promise of arrival at a destination that can never be reached. An attachment to the possibility of forward progress and, ultimately, a cure may prolong the punitive time of waiting. This hope can spur endurance: it makes the chronic seem a little more bearable for a little longer because, after all, change is just around the corner. When waiting is a consequence of fiscal austerity, it is these hopeful affects that cause everyday austerity to recede and become less perceptible.

The potentiality of waiting can prove agonising; simultaneously, potentiality can offer a means of enduring the chronic (Baraitser, 2017). As Povinelli (2011) suggests, when life is lived in straitened circumstances, violence and suffering are rarely spectacular events: rather they are quasi-eventful accumulations of "ordinary, chronic and cruddy" happenings that hover below the threshold of eventfulness and "never quite achieve the status of … having taken place" (Povinelli, 2011, p. 13; see also Wilkinson & Ortega-Alcázar, 2019). Yet when violence is quasi-eventful, so too is endurance and survival. Living on becomes a matter of dwelling within this immanent potentiality, and the possibility of becoming otherwise. For Povinelli, endurance means remaining in those moments where an otherwise seems possible, even if it never comes into being; of dwelling in these worlds and their uncertainties, rather than retreating to the comfort of the normative (see Baraitser, 2017).

In the remainder of this paper, I use this dual framing of potentiality – as simultaneously a means of violence and of endurance – to analyse the "holding pattern." Tom uses this phrase to describe his circulation between different services, without ever "touching down" in any one of them. Building on this, I argue that the holding pattern is experienced as a time of waiting that is static and suspended, yet that remains alive with the potential of becoming otherwise. I suggest that mobility serves to temporarily animate the limbo of waiting, creating optimism that a return to progressive time is imminent, before this optimism reveals itself to be cruel (Berlant, 2011). In practice, the circulation of people in the holding pattern serves to sustain punitive durations of waiting in conditions where meaningful care remains a remote possibility. In turn, this camouflages the everyday consequences of austerity, concealing the withdrawal of care beneath a temporality of perpetual delay. Yet potentiality is also the condition of survival in these circumstances. The practices undertaken by those within the holding pattern are quasi-eventful insofar as they are never actualised: they don't lead to new social projects, nor do they realise new ways of being in the world (Povinelli, 2011). Ultimately, they sustain a fantasy of an otherwise that makes the unbearable affectively bearable, at least for a time. Taken together, these interwoven forms of potentiality make

up an "all-too-human geography," defined by Wilkinson & Ortega-Alcázar as "a messy paradoxical state, a scene of exhaustion and endurance, diminishment and fortitude, decay and aliveness" (2019, p. 158).

4 | RESEARCHING QUASI-EVENTS

Quasi-events pose a methodological challenge. They appear as subtle disruptions against the backdrop of the everyday: nothings that may turn into somethings, but often don't. To research them requires attuning to the emergence of potentialities and their truncation: these become barely apparent as small shifts of affect, mood, or intentionality. I made use of two research methods in this endeavour: participant observation and biographical interviewing. Between 2018 and 2020 I regularly attended two peer-support groups and a day centre for mental health service users/survivors in the East of England.[2] My participant observation often involved sitting and waiting alongside service users/survivors in spaces where little eventful ever seemed to happen. Yet simultaneously these spaces were alive with hopes, aspirations, and expectations, even if few of these projects had any life beyond their initial articulation. Across repeated attendances[3] I began to trace the trajectories of quasi-events: projects that never materialised, or were snuffed out for "ordinary, chronic and cruddy" reasons (Povinelli, 2011, p. 13). This involved close attention to my own affective experience, the intensities that I felt as my body became implicated with others; I sought to record the moments when I was drawn into shared feelings of hopeful potential, as much as more despairing instances when futures felt foreclosed.

This paper draws mainly on evidence from my second method: in-depth biographical interviews.[4] However, the two methods are inseparable inasmuch as participant observation shaped the entire interview process: from my sensibility and lines of inquiry to the atmosphere of interviews and the choices of participants. I conducted 22 interviews with service users/survivors recruited across the three services, each lasting between 30 minutes and two hours. The biographical structure encouraged my participants to describe changes over time, connecting their individual narratives to the broader historical, social, and economic context (Andrucki & Dickinson, 2015) of austerity. Their narratives also included false starts, diversions, and hopes that went nowhere: in other words, quasi-events surfaced throughout. I followed up my interviews at subsequent informal meetings. Once I had begun work on this paper, I carried out formal follow-up interviews with Tom and Paula, who were becoming its protagonists. By focusing on the smaller subset of their two interviews (with additional insights from three more; see Table 1), I hope to do justice to the richness of these narratives (Wilkinson & Ortega-Alcázar, 2019). I am not claiming that the accounts given by Tom and Paula are completely representative of the wider sample. Instead, I chose them because they offered particularly vivid articulations of concepts and themes that came through within other narratives; indeed, it was my encounters with Tom and Paula that helped me to identify these themes. Waiting was a common thread tying together almost all of my interviews and ethnographic encounters. But it was Tom who pointed out the cycles of optimism and deflation that accompany transfers of care, and who named this alleviation of stasis as the "holding pattern." Meanwhile Paula showed me how the practices through which waiting is endured are often quasi-eventful, meaning that – like the holding pattern – they are also a matter of potentiality.

5 | PRODUCING THE HOLDING PATTERN

The holding pattern emerges from a wider political-economic context where outsourcing, marketization, and reregulation meet the "cutting demands of austerity" (Philo & Parr, 2019, p. 243). In my field site (as elsewhere in the UK), mental health services were being operated by charities, non-profits, private providers, and the NHS (Parr, 2008), and there was a general perception among service users/survivors that all were greatly overstretched. This context shaped the two services that I attended. The peer support groups and the day centre were operated by charitable entities; both had been subject to

TABLE 1 Biographical details of key participants

Pseudonym	Biographical details
Glen	Male, 50s, white, unemployed (former factory worker), first contact with psychiatric services in 1990
Liz	Female, 40s, white, unemployed (former social worker), first contact with psychiatric services in 2008
Paula	Female, 30s, white, factory worker, first contact with psychiatric services in 2012
Philip	Male, 60s, white, retired on medical grounds (former administrator), first contact with psychiatric services in 1984
Tom	Male, 70s, white, retired on medical grounds (former engineer), first contact with psychiatric services in 1990

significant cuts. The peer support groups were commissioned by the local authority, which was in the process of shedding 20% – around £5 million – from its mental health budget. Consequently, the groups were mostly run by unpaid volunteers, where previously support had been offered by paid staff. The volunteers tended to be current and former service users, and their volunteering was framed as vital to their recovery, a step on the road back to paid employment (Beresford & Russo, 2016; Laws, 2013). Meanwhile, the day centre had been funded by the NHS for a decade, but in 2015 its budget was slashed to zero. It now got by on a series of short-term grants from charitable foundations, amounting to around 30% of its former income.

Budget shortfalls give rise to endemic waiting. The small minority of participants who were formally under the care of higher-tier secondary services[5] waited three to six months between each visit to their psychiatrist. A wait of over six months was required to get added to the caseload of a community psychiatric nurse (CPN). Even the crisis team – intended to offer a rapid emergency response – were subject to delays of hours or even days. Waiting was also widespread in lower-tier mental health services. Despite being shielded from recent budget cuts (Pickersgill, 2019), the Improving Access to Psychological Therapies (IAPT) service – which offers talk therapy for "mild" anxiety and depression – ran a waiting list of around six months, as did the day centre. To meet a support worker from one of the peer support groups was a two-month wait.

Simultaneously, marketisation and outsourcing had fragmented the local service landscape. Gatekeepers could refer a case to a plethora of different organisations. The first gatekeeper encountered by the majority of my participants was their general practitioner (GP), who would make a first referral. In Liz's case, she reported her experiences of distress to her GP:

> And then they referred me on to, erm […] It's a place up in [town …] and they only see you for like six weeks so it's mainly for people who only have very minor sort of like depression or minor anxiety and they um realised that my mental health state was too severe for them to cope with so they referred me back to the GP. (Liz)

The "place up in town" was IAPT. After receiving medication from her GP, Liz waited for an IAPT appointment, but was reassessed when she arrived there and was judged "too severe." She was sent back to the GP, with the promise of another onward referral, to begin the whole process over again. This cycle – of waiting, reassessment, re-referral, and more waiting – is the basis of the holding pattern.

These reassessments and re-referrals can be thought of as moments of "officious reregulation" (Philo & Parr, 2019, p. 243). In part they arise from a sense that the risk posed by a psychiatric patient (to self or others) needs to be held somewhere in the system (Moon, 2000); at the same time, when resources are scarce, gatekeepers are incentivised to lower demand and remove risk from their caseloads, such as when Liz was judged "too severe … to cope with." In the experience of my participants, these transfers of care to other services was often framed in humanitarian language, suggesting that they would lead to the provision of more suitable (and therefore more personalised) care:

> I think most of the time it is just, I will refer you to the assessment team, or I will refer you to the psychologist at the hospital, and it's just almost like passing on, isn't it, because they have their time to, they have a lot on their caseload to do, and it's quite complex, I think, mental health, it's very complex with some people, so it is a case of, haven't really got the time, so let's pass you on to this, and they can help you better. (Paula)

However, in practice, those who were most likely to find themselves circulated were those who troubled care institutions in some way (Beckingham, 2019; Philo & Parr, 2019). For many of my participants, the issue was that they found themselves in an interstitial space: too unwell to work or to be permitted to access lower-tier services such as IAPT, but not "severe enough" to require intensive monitoring and to be admitted to secondary services. These assessments were based partly on anticipatory geographies (Anderson, 2010) of risk, and partly on determining whether the "affective temperature" of the person was cool enough to be managed through less intensive interventions (McGrath & Reavey, 2016, p. 63). It is likely that I encountered so many people in the interstices because they tended to be drawn to the peer groups that I was accessing: these spaces had no formal criteria for admission, much like the drop-in centres they replaced (McGrath & Reavey, 2016; Parr, 2000).

A second way in which service users/survivors could cause trouble and find themselves circulated was if they actively challenged the judgements of mental health professionals. As Paula put it:

> I've been thrown around so much […] and the assessment team must hate me now […] [laughs] I'm a bit of a nightmare. […] I've fought for everything that I've been given. (Paula)

In her own telling, Paula had pushed back volubly against the professionals who determined her care plans. On one occasion, she had a falling out with the leader of a time-limited "recovery course" that she was completing for a second time, in the absence of any other care provision. Feeling that the course wasn't working for her, and facing significant financial pressures, she made the decision to return to work. As a result, she missed several sessions of the course and was discharged. At the time, she was attempting to gain the support of a CPN:

> [My GP] wrote a very detailed summary of why I need a CPN, and my conditions, and how it affects me, and how serious it was and I got a phone call that made me very angry, and it said, um, "yes, because you didn't complete the course, and you chose to go back to work" – yes, I chose to go back to work, I wasn't, didn't have to – "that we can't actually give you a CPN, and we can't actually help you." (Paula)

Liz similarly found herself discharged from a service on the grounds of her difficulty:

> I was homeless as well and the council were not very helpful with me there. […] And they erm sent me to this place and the landlord was there and he looked to me at the time identical to someone who raped me when I was a teenager and I thought, I can't see this person every day, or once a week even because this is just gonna trigger sort of flashbacks and this all the time and I told the council this but they said because I'd refused a place they were not willing to help me any more […] Basically it's like one strike and you're off, no matter what the reason. (Liz)

However, none of these discharges was final. Each involved a re-referral to another service, meaning that responsibility for risk was being held by a professional somewhere; for my participants, each involved a considerable period of waiting and stasis. Yet this waiting was not experienced as dead time. The multiple mobilities involved in these referrals – circulations of case notes into new systems, arrivals of letters, visits for initial assessments – created their own anticipatory geographies, as my participants found themselves looking forward to the time when they would arrive at a destination offering care and cure. These were affective experiences, emerging from new alliances between bodies, objects, forces, and spaces (Duff, 2016). It was in these periods that the potentiality of waiting was most keenly felt, as hope: an opening out of the diminishing dimensions of daily life, and an orientation towards a better future (Anderson, 2006).

6 | HOPE IN THE HOLDING PATTERN

The relationships between stasis and mobility, diminishment and hope can be clearly located in Tom's narrative of the holding pattern. His story began with a referral to IAPT:

> I went to my GP back in May, last May, he could see that I was distressed, and he said okay, well you can, if you ring up IAPT again, then they'll, somebody will ring you, which they did, but then I was told, well it's a six-month waiting list, but somebody will ring you every three weeks. […] Which wasn't really a great deal of help. (Tom)

The regular check-ins over the phone were likely motivated by surveillance and risk management. Despite Tom observing little therapeutic benefit, the regularity of the calls served to mark time. The monotony of his waiting was disrupted and he was reminded that the time of treatment was coming closer: a shift from the forth-coming into the future (Jeffrey, 2008). However, the IAPT treatment never arrived:

> And um, then I had, back in early autumn, I felt unwell and I went to, I rang up the surgery and I said, can I see someone? Oh well, there's no one you can see. You can see the matron, so I said okay, saw the matron, soon as I went in there I burst into tears and she said, "I see you're on primary care, I'm going to put you into secondary, because," she said, "given your history, you are outside of what primary care can provide." So, I've now been diagnosed with PTSD. […] She said, "I will make a phone call now, you will get communication from IAPT because they will want […] [that] part of it cancelled, which you will have to do." (Tom)

As a result of his heightened affective temperature (McGrath & Reavey, 2016), Tom was judged to be "outside of" the capacities of primary care. He was told to cancel his place on the IAPT waiting list, and then transferred to a new service. He waited to travel to a new site of treatment, a movement anticipated by his case becoming mobile: the transfer of his medical notes to a new system, the shifting of his name onto a new list. Then, eventually, Tom was allowed to visit the new treatment site:

> And then, now, I'm going to Hamilton House […] having um really an assessment of, of how I'm going to cope with the treatment. (Tom)

Yet this transit didn't end in an arrival. Tom's distress was not treated; instead, he was held in suspense and assessed, in preparation for an unspecified time when he would be ready for treatment. Nonetheless, Tom was in a buoyant mood throughout our interview, expressing optimism through expansive gestures and an ebullient tone of voice. The process of assessment and the multiple relations formed throughout cultivated affects which Tom embodied as hope. The movement between sites and services brought the potentiality of waiting to the fore (Bissell, 2007); each transfer opened up the possibility of becoming otherwise, of suspense transforming into progress.

However, by the time of a follow-up meeting several months later, these movements had revealed themselves to be no more than a holding pattern. Tom explained that he had once again been deemed too severely unwell and discharged from the programme of treatment he was being prepared for. He was then transferred to a waiting list for counselling but had missed a session following a disagreement with his counsellor. He had then been discharged from the service for non-compliance. Tom's optimism had proven to be cruel (Berlant, 2011): his hope for the treatment that would resolve his mental health issues, and offer him a sense of progression, had revealed itself to be illusory. As he bleakly summarised:

> [O]nce this treatment stops, it's a metaphorical cliff edge. You stop, and then you're just looking down into the abyss. It's either on and then it's off, there is no gradual running down of it […] it stops and then you're lost, you're in the wilderness again, and unless you can gradually come back to reality, you're going to very quickly slip down into it. (Tom)

The time of waiting, held at a distance from the fantasy of treatment and forward progress, felt empty and barren, a "wilderness" distinct from the feeling that you were moving forward, into a "reality." In times of hope, mobility between different sites of care and the preparation for treatment gave rise to an optimism that could sustain these periods of waiting; in its absence, a person was left to tumble "into the abyss." These are the two poles of potentiality within the holding pattern: on the one hand, a possibility for admission into services, treatment, and forward progress; on the other, abrupt discharge, abandonment, and stasis.

Through promises of forthcoming personalised provision, temporalities of delay, and affects of hope, the holding pattern is an attempt to foreground the first of these poles. In turn, this can serve to camouflage the depths of austerity, by transforming absences of care – the material and felt consequences of fiscal retrenchment – into periods of hopeful waiting. Yet this strategy was only partly successful. Around half of my participants expressed the view that there was plenty of care available; the others narrated their experiences as repeated abandonment. The latter group was mostly older: these were often people who had been subject to the chronic spatial trauma of repeated cuts over the course of decades (Pain, 2019; Shaw, 2019). As one put it, after the closures of the large local asylum and then the shuttering of several day centres, "all that's left for me is this place [the peer group] and the doc" (Philip). Nonetheless, those in the latter group were also reliant on potentiality when enduring chronic waiting.

7 | ENDURING THE HOLDING PATTERN

The affective optimism that arose from the mobilities of the holding pattern – even if this was cruel – was one means through which participants endured. Each transfer of care felt like a new start and a new possibility, even if no care was actually forthcoming. Responsibilisation (Teghtsoonian, 2009) played a crucial role in this camouflaging of austerity: the participants who felt satisfied with the level of care they received also tended to blame themselves for any shortcomings. Liz's narrative included extended circuits between different services with long periods on waiting lists, frequent discharges from care, and even forced homelessness, yet in her view:

> [T]here's a lot of support if you want it, there's a lot of support, but you've got to be in the right place, headspace to, to, find it and to be, y'know, sort of like accepted, I suppose. (Liz)

The flaws in her experiences of service provision were, according to Liz, her own fault: a consequence of her not being in the right "headspace." Similarly, Glen suggested that the limited care he received following a series of suicide attempts was the result of his own negligence:

> I just told [the crisis team] a load of lies, like, just said get off my back, obviously I shouldn't have done that at the time … When I first got divorced … [my doctor] advised me, go to these meetings and that, obviously I didn't, I left it and left it and left it. (Glen)

Responsibilisation can sustain a belief that adequate care is, spatially and temporally, almost within reach: the only barrier is a person's inappropriate decisions or "headspace."

Conversely, for those like Paula and Tom who grew disillusioned with its promises, the holding pattern became more challenging to endure. In response, these participants adopted practices that helped them to dwell within the potential of being otherwise. These project a future that is never actualised, even as it creates the conditions for carrying on. These are quasi-eventful practices: even if they never reach the threshold of actually taking place, they are nonetheless more eventful than nothing (Povinelli, 2011).

Having been discharged from services because of the trouble she caused, Paula was referred to the day centre:

> So I rang [them] up and I explained the situation, and they said, "yeah, we're not actually taking referrals, um, until January." And this was in, like, September. […] So then I just thought, well okay, that's just great. So I rung the assessment team back, and I said, "well, they don't take referrals until January, so what do I do in the meantime?" "Oh, well, you'll have to wait until January." Well, what am I going to do for four months then? Without nothing. (Paula)

She went on to describe how she had adapted to this chronic waiting:

> I just find my own ways of handling how I feel, my moods, the suicidal ideation, I find ways of keeping myself safe, so. […] So, it's a bit of a weird one […] when I first told [my new doctor] this, she went, *(loud gasp)* "oh my goodness," but my old doctor understood, so it's not crazy. But erm, so, [normally] people who want to commit suicide want to do it because they can't take life, whereas with suicidal ideation it's something I find exciting […] It's something that I want to do, so, for me, what works for me, is, actually giving into that temptation enough to still be safe. So for a long time I would go and sit at the local train station for about five hours, and be somewhere I could if I wanted to be and that was enough to not want to do it. […] But yeah, so it's […] almost, playacting, playacting it out so it's enough to quench that needing to do it without doing it. (Paula)

Paula sits at the railway station, day after day, watching trains roar through and fantasising about jumping. On the one hand, watching the trains seems to give her a sense of possibility – a thrill of doing something radical that appears to contain the prospect of an escape, a way of transcending the struggles of her present. The repetition of her returns to the train station suggests a kind of cultivation, an affective labour to maintain potentiality within her waiting. Yet this future was never actualised; nothing happened. To an outside observer, Paula would have been simply a woman sitting on a bench on the platform, waiting for her train to arrive: these repetitions were quasi-events (Povinelli, 2011). At the same time, the otherwise that Paula is cultivating is suicide: the potential of death. Even as her practice suggests a possibility of escape, within that escape there is also a void, an embrace of negation – a reflection of her present state of being left for months at a time "without nothing."

Paula's account is deeply troubling, and it is important to avoid romanticising her version of endurance. Even if her story can be theorised in terms of potentiality and quasi-events, there is also an echo here of a far older geography of mental health services. This scenario – in which a person is driven to play out their own suicide due to an absence of meaningful care – seems, in the words of Dear and Wolch, to "presage the collapse of the human-service system and an abandonment of those in need" (1987, p. 254). Paula herself recognised this:

> I'm working full time, not asking for money, I just want some support, I just want someone to come alongside me and once a month go, are you doing alright? How are you doing? (Paula)

This echoes Baraitser's definition of care as an "arduous temporal practice of maintaining ongoing relations with others and the world" (2017, p. 4). When life feels in limbo care "may turn out to be the gesture that gives time" (2017, p. 17). Yet, as a result of the budgetary constraints of austerity and growing pressures within the care system, the prospect of this kind of care being delivered by mental health services seems increasingly remote. In its absence, others may be forced into modes of endurance that also bring them closer to oblivion.

8 | CONCLUSION

As potentiality weaves through the findings of this paper, so it also shapes the conditions of their production: the possibility of an otherwise is omnipresent. The concept of the holding pattern emerged from encounters with participants at particular moments during journeys across austere landscapes of mental health provision, and this timing shaped the narratives that I received. I could have finished meeting with Tom sooner and been left with a story of overarching optimism; had mine and Liz's paths crossed one more time, perhaps I would have found her in disillusionment. The contingency of these findings is reflective of the "absent-presence" of everyday austerity (Hitchen & Raynor, 2020, p. 186), as a "series of fragmented encounters" that is always threatening to fall apart (Raynor, 2017, p.202). When austerity holds together, and is recognised, this can undermine the claims of humane universalism made by welfare state institutions. As the persistent and repetitive "naming of an end" to austerity (Hitchen & Raynor, 2020, p. 187) coincides with demands for further cuts (Giles & Parker, 2020),[6] the gap between the hopeful rhetoric of service provision and the material conditions of the British welfare state will continue to grow. In such a context, the camouflaging of austerity is likely to prove increasingly important to the legitimation of state services. This demands more geographies of life at the sharp end of the cuts, to understand where and how austerity can be made to disappear. But more significantly, this suggests a need for more institutional geographies of beleaguered (welfare) state institutions, to better understand the camouflaging strategies of those who wield the knife and determine where it falls.

The dissipation and camouflaging of austerity poses a particular problem for organised resistance against austerity: how to mobilise against a multifaceted background phenomenon that intensifies and recedes over time (Hitchen, 2019). This paper argues for the significance of forms of resistance that are less organised, neither grand nor revolutionary. The troubling cases (Philo & Parr, 2019) I analyse are examples of actually existing resistance: those which institutions struggle to metabolise, which cause them indigestion, and perhaps, in the long run, can bring about dietary change. A "quieter" politics (Wilkinson & Ortega-Alcázar, 2019, p. 164) of this kind does not rely on recognising and naming a phenomenon. It is not a hopeful politics of transcendence because it does not necessarily lead to change; the seductions of hope can, after all, prove cruel (Berlant, 2011). Nor is it a heroic politics of transformation, because nothing eventful is happening. What is taking place in the actions of someone like Paula is the patient cultivation of conditions of possibility amid enervating circumstances, and this paper suggests that further research is needed to consider the relationship between these practices of grinding resistance against slow violence, and wider, deeper processes of systemic change. If nothing else, these practices resist the conditions of "capitalist realism," whereby it becomes impossible to imagine alternate futures (Fisher, 2009). While this may not seem like much when arrayed against the totalising forces of late capitalism, it is always more than nothing. Stubborn, persistent practices are widespread. Reliant on the immanence of potentiality when all else might seem futile, they do the work of keeping the possibility of an otherwise alive.

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author on reasonable request.

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ENDNOTES

[1] Tom first used this term during an informal interview at a drop-in group in April 2018. I noticed resonances with narratives shared by other interviewees. Tom and I further refined the concept during a follow-up interview in August 2019.

[2] I attended all groups with the consent of service users/survivors and was open about my status as a researcher. I received ethical approval from the Department of Geography at the University of Cambridge and from an ethics panel convened by one of the services. The project also included two months of participant observation with mental health commissioners in the local authority, as well as in-depth interviews with frontline workers, service managers, commissioners, and local councillors.

[3] Over the two years I alternated between intensive periods of attending each daily or weekly session at one of the services, and more intermittent attendance.

[4] Interviews were audio recorded with participants' permission, and then transcribed and coded. The names of participants and other identifying details have been changed to preserve anonymity.

[5] Services for those deemed to have the most acute mental health issues.

[6] Following marked increases in government spending in response to the COVID-19 pandemic, the Chancellor has promised 'no return to austerity' (Schomberg & Sandle, 2020, n.p.), yet a public sector pay freeze in combination with a lack of funding for decimated local authorities arguably represents 'austerity by stealth' (Giles & Bounds, 2020, n.p.).

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